Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Annabella Landsberg a prisoner at HMP Peterborough on 6 September 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Annabella Landsberg died in hospital on 6 September 2017 from multi-organ failure, caused by diabetic ketoacidosis, rhabdomyolysis and aspiration pneumonia, while a prisoner at HMP Peterborough. She was 45 years old. I offer my condolences to Ms Landsberg's family and friends.

The events leading up to Ms Landsberg's death are truly shocking. After being restrained by staff on 2 September, she was left lying on her cell floor in the segregation unit for 21 hours without being examined by healthcare staff. When she was finally examined on 3 September, she was found to be extremely ill and was sent to hospital, where she remained in critical care until she died. Both discipline and nursing staff assumed initially that Ms Landsberg was play-acting and it took them far too long to seek managerial intervention and to carry out appropriate clinical examinations.

Ms Landsberg's clinical care fell far short of that which she might have expected to receive, and we agree with the clinical reviewer that staff might have been able to prevent her death.

Peterborough will need to take robust action to address the serious failures in care by both discipline and healthcare staff that occurred in this case.

I am copying this report to the Head of Custodial Contracts in HM Prison and Probation Service to note my serious concerns about Ms Landsberg's treatment.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

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Summary

Events

1. In February 2016, Ms Annabella Landsberg was remanded in custody to HMP Bronzefield, charged with committing further offences while subject to a suspended sentence. She was later sentenced to four years and six months in prison. On 11 May 2017, Ms Landsberg was transferred from HMP Send to HMP Peterborough.

2. Ms Landsberg had Type 2 diabetes, which was well controlled by diet alone. She was receiving several prescribed medications. Although she was clinically obese, she seems to have been reasonably fit and well.

3. Ms Landsberg had a history of disruptive behaviour and was held in the segregation unit on a number of occasions. She was moved there again on 30 August.

4. At 5.50pm on 2 September, Ms Landsberg sat down and then lay down on her cell floor in the segregation unit when a nurse tried to give her medication. When she resisted staff efforts to lock her cell door, she was restrained. The incident was not filmed as an officer had removed her body-worn camera.

5. Ms Landsberg was then left lying on her cell floor for the next 21 hours. She did not eat any of the food that was placed in her cell and she was not seen to drink any fluids.

6. Although a nurse made three visits to Ms Landsberg's cell on 3 September, she did not examine her. At about 3.00pm, another nurse went into Ms Landsberg's cell, examined her and realised that she was seriously unwell. An emergency ambulance was called and Ms Landsberg was taken to hospital and placed in intensive care. Ms Landsberg died in hospital at 4.56pm on 6 September.

Findings

7. After she had been restrained on 2 September, Ms Landsberg remained on the floor of her cell and did not get up again. The pathologist concluded that that it was not possible to determine whether Ms Landsberg lay on the floor because she was unwell as a result of her diabetes, or whether she initially lay on the floor for another reason and, while lying there, developed medical complications which led to her death.

8. Whatever happened, it is unacceptable that she was left lying on the cell floor for 21 hours. Neither the clinical nor discipline staff responsible for Ms Landsberg's welfare provided her with appropriate care, treatment or support during the extended period that she lay on the floor during 2 and 3 September 2017.

9. We consider that a member of healthcare should have been asked to examine Ms Landsberg in her cell once she had had a chance to calm down after the use of force (in line with the requirements of PSO 1600).

10. If she had been examined earlier, staff may have been able to prevent her death.

11. Staff at Peterborough could have accessed vital information about Ms Landsberg having Type 2 diabetes if they had removed a sharing restriction on her records.

12. We agree with the clinical reviewer that there were deficiencies in the way staff managed Ms Landsberg's medicines and diabetic care.

13. Nurses who completed segregation health screen assessments failed to record and consider whether Ms Landsberg had previously overdosed on drugs.

14. The decision to segregate Ms Landsberg, while in line with Peterborough's policies, may have been disproportionate to the risk she posed.

15. Potentially valuable evidence about the use of force on Ms Landsberg was not captured as an officer removed her body-worn video camera while still on duty.

16. Although Ms Landsberg was not restrained when she was taken to hospital, when the escort officers noticed Ms Landsberg growing restless and moving her hands in hospital, they applied handcuffs, without seeking managerial approval.

Recommendations

- The Head of Healthcare should ensure that:
    - A particular nurse is referred to the Nursing and Midwifery Council to consider her fitness to practise;
    - staff understand how SystmOne record-sharing restrictions can be removed;
    - the further learning needs of all the clinical practitioners named in the clinical review are reviewed; and
    - thorough reviews about the healthcare capability at all levels, prescribing practices and diabetic care are conducted.
- The Director and Head of Healthcare should ensure that all medical staff who undertake segregation health screen assessments record incidents of potential self-harm properly and, in light of these, consider carefully the prisoner's suitability for segregation in line with Prison Service Order 1700.
- The Director should review the use of segregation in the context of the interaction of the prison's ASBIP protocol, the Incentives and Earned Privileges scheme and the provisions of PS0 1700, in particular the principle that segregation should only be used as a last resort and that any decision to segregate a prisoner is entirely proportionate to the risk they pose.
- The Director should ensure that segregation staff understand fully their responsibilities and, in particular, that:
    - staff selected to work in segregation have sufficient experience and training for the role;
    - they engage with prisoners in a meaningful way and record these interactions in the prisoners' history sheet;
    - they brief the duty Director fully about all significant events in the past 24 hours; and

    - they recognise and understand the circumstances in which they should seek managerial guidance about the prisoners in their care.

- The Director should ensure that where it is not possible for a healthcare practitioner to examine the prisoner safely immediately after a use of force incident, the prison should arrange for healthcare staff to visit again later when the prisoner has had a chance to calm down.
- The Director should review the prison's protocol on body-worn video cameras to ensure that officers do not remove their body-worn cameras until they have ended their shift.
- The Director should review the local protocol on the use of body-worn video cameras to ensure that it accords with the instruction in PSI 04/2017.
- The Director should commission a disciplinary investigation into the actions and inaction of the segregation officers who were responsible for Ms Landsberg's care on 2 and 3 September 2017.
- The Director should ensure that hospital escort staff take advice from an appropriate manager before applying handcuffs to a prisoner.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

18. The investigator obtained copies of relevant extracts from Ms Landsberg's prison and medical records.

19. The investigator interviewed 14 members of staff.

20. NHS England commissioned a clinical reviewer to review Ms Landsberg's clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical and non-clinical staff.

21. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation, who gave us the results of the post-mortem examinations. We have sent the Coroner a copy of this report.

22. One of the Ombudsman's family liaison officers contacted Ms Landsberg's brother to explain the investigation and to ask if he had any matters that the family wanted the investigation to consider. He did not raise any specific matters.

23. The investigation assessed the main issues involved in Ms Landsberg's care, including treatment provided by nursing and discipline staff, the use of body-worn cameras, security arrangements for hospital escorts and the liaison with her family.

Background Information

HMP Peterborough

24. HMP Peterborough is operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. The women's side of the prison holds almost 400 women. There is 24-hour healthcare provision. All healthcare is provided by Sodexo under the provisions of their contract with the Ministry of Justice.

HM Inspectorate of Prisons

25. The most recent inspection of the women's side of HMP Peterborough was in September 2017. Inspectors found that use of force was high, with 129 incidents in the six months before the inspection. Control and restraint techniques had been used in 83 incidents. Inspectors noted that while paperwork for use of force incidents was complete and generally detailed, there was very little evidence of de-escalation in either the paperwork or in the videos reviewed, and they were not satisfied that force was always justified. Inspectors also noted that while staff had body-worn video cameras and all wings had CCTV, too few video recordings of incidents were made or retained. The incidents observed showed that verbal instructions and interactions with women during incidents involving force were not always respectful.

26. Inspectors found that the segregation unit was very clean and tidy and the rooms were furnished appropriately. Inspectors noted that the rates of segregation were slightly higher than they usually saw in a women's prison, although most women spent relatively short periods in the unit. Inspectors found that the female prisoners spoke highly of some of the segregation staff, but they observed that a number of staff interacted too little with the women in their care. Inspectors found that there were deficiencies in healthcare leadership and in governance arrangements, and that too many staff did not have clinical supervision.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 2017, the IMB reported that the prison treated female residents humanely and decently, and that healthcare provision was broadly in line with that in the community.

Previous deaths at HMP Peterborough

28. Ms Landsberg was the sixth female prisoner to die at HMP Peterborough since 2015. Of the previous deaths, four were from natural causes. There were no significant similarities with the circumstances of the other deaths.

Segregation units

29. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving

punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The unit at Peterborough is known as the Separation and Care Unit and comprises 12 cells.

Use of Force

Justification for the use of force

30. Prison Service policy on the use of force is set out in PSO 1600. This states that the use of force is "justified, and therefore lawful, only:

- If it is reasonable in the circumstances
- If it is necessary
- If no more force than is necessary is used
- If it is proportionate to the seriousness of the circumstances".

31. The PSO goes on to say that the issue of 'reasonableness' is a matter of fact to be decided in each individual case:

> "Each set of circumstances are unique and are to be judged on their own merits. Factors to be taken into account when deciding what is 'reasonable' will be things such as the size, age and sex of both the prisoner and the member of staff concerned in the use of force and whether any weapons are present."

32. On the question of whether force is 'necessary', the PSO says:

> "The first distinction to make is between force used in 'self defence' (can more easily be demonstrated to be 'necessary') and force used because someone has refused to obey a lawful order. It is not enough that a prisoner be given any 'lawful order' to do something and has refused to do so.
>
> "It is important to take into account the type of harm that the member of staff is trying to prevent – this will help to determine whether force is necessary in the particular circumstances they are faced with. 'Harm' may cover all of the following risks:
> - Risk to life
> - Risk to limb
> - Risk to property
> - Risk to the good order of the establishment
>
> It is clearly easier to justify force as 'necessary' if there is a risk to life or limb."

33. On the issue of 'proportionality' the PSO says:

> "Staff should demonstrate a reasonable relationship of proportionality between the means employed and the aim pursued. Action taken is unlikely

to be regarded as proportionate where less injurious, but equally effective alternatives exist."

34. PSO 1600 goes on to say that staff should always try to prevent a conflict wherever possible and that control and restraint "must only be used as a last resort after all other means of de-escalating (e.g. persuasion or negotiation) the incident, not involving the use of force, have been repeatedly tried and failed". However, the PSO also recognises that sometimes staff may "have no other option than to use force" and says that "when force has become necessary C&R (control and restraint) techniques are always the preferred option".

Medical conditions

35. Annex D of the PSO sets out the potential adverse effects of the use of force on prisoners that staff need to be aware of. This includes the danger of positional asphyxia, especially in the case of prisoners who are obese or who have other health problems, such as diabetes.

The use of force paperwork

36. The PSO also says that whenever any type of force has been used, all the staff involved should complete a statement of the events, to present the facts as each officer witnessed them, in order to build as clear a picture of the events that led to the use of force and of what happened during the use of force.

37. In addition, whenever force is used, a doctor or registered nurse must examine the prisoner as soon as possible afterwards and must complete a Report of Injury to Prisoner (F213) form even if the prisoner appears not to have sustained any injuries.

38. In May 2016, this office published a Learning Lessons Bulletin, *Use of Force – further lessons*. In this we recognised that it may not always be safe for a member of healthcare to enter a cell and examine a prisoner immediately after a use of force incident. We said, however, that we do not consider that a brief look through the cell door hatch meets the requirement in PSO 1600 for a prisoner to be examined by a healthcare practitioner. And that, where it is not possible to conduct a proper examination immediately after an incident, the prisoner should be seen again by healthcare a few hours later.

Body-worn video cameras

39. Body-worn video cameras (BWVCs) have been in use in public sector and contracted (private) prisons for a number of years. When used effectively, a BWVC allows visual and audio images to be captured to provide a clear record of events to protect both staff and prisoners. BWVCs must only be used for overt recording. Prison Service Instruction (PSI) 04/2017 gives instruction on the use of BWVCs in public sector prisons. Peterborough has its own protocol on the use of BWVCs. The protocol explains that BWVCs are to be used in a variety of settings including recording of planned or spontaneous incidents and for recording interactions with potentially aggressive or disruptive prisoners. The protocol states that BWVCs must be worn at all times by those staff to whom they have been assigned.

Key Events

40. On 4 February 2016, Ms Annabella Landsberg was remanded to HMP Bronzefield, charged with robbery and assault. She was later convicted and sentenced to four years and six months in prison. Ms Landsberg was transferred to HMP Send in March 2017.

41. On 11 May 2017, Ms Landsberg was transferred to HMP Peterborough. The reception nurse noted that she had Type 2 diabetes, which she controlled through her diet, and that she had been prescribed various medications, including triumeq (anti-viral medication used to treat HIV) and loratadine (an antihistamine). The nurse noted that Ms Landsberg was not suitable to have medication in-possession. (All prisoners are assessed to check if they can be trusted to hold medication in possession and to take it take it in accordance with their prescription.)

42. At a secondary health screen on 24 May, a nurse assessed Ms Landsberg as safe to hold medication in-possession. The nurse recorded that Ms Landsberg was 5' 8'' and she weighed 16st 7lb.

43. On 8 June, Ms Landsberg said that she had taken an overdose of some of her triumeq and loratadine tablets. A nurse contacted Public Health England for advice, and she was told that Ms Landsberg was not at risk from the amount of medication she said that she had taken. The nurse did not confiscate the remainder of Ms Landsberg's in-possession medication. Later that day, Ms Landsberg reported that she had taken all the remaining tablets. This time, Public Health England advised that Ms Landsberg should be assessed in hospital. She remained fit and well, and was discharged from hospital in the early hours of 9 June.

44. On 11 July, Ms Landsberg told officers that she had taken an overdose of haemorrhoid suppositories that she had been prescribed and given in-possession several days earlier. Ms Landsberg again came to no apparent harm from this possible overdose.

45. Ms Landsberg was warned many times at Bronzefield, Send and Peterborough about inappropriate behaviour. This included allegations of touching other prisoners inappropriately, making inappropriate comments and stealing or concealing property belonging to others, including a pair of scissors. A clinical psychologist noted that she seemed unaware of personal boundaries after she tried to rearrange the clinical psychologist's hair during an assessment. In addition, there was an incident in October 2016 when Ms Landsberg was noted to have barged past a male officer at HMP Bronzefield in an attempt to leave her spur.

46. Staff at Peterborough tried to manage Ms Landsberg's behaviour using an 'anti-social behaviour improvement plan' (ASBIP). She was warned that her behaviour meant that she could not be given a job, there were times when her incentives and earned privileges (IEP) entitlement was reduced to basic, and she spent time in the segregation unit.

47. At an ASBIP case review on 29 August, Ms Landsberg was told that her behaviour had not improved. This included recent incidents when other prisoners had complained that Ms Landsberg had removed their clothing while they were showering and had also peered at them over the shower doors. Ms Landsberg was also asked about 13 missing pages from her ASBIP book which included names of other prisoners who had complained about her. Ms Landsberg denied knowledge of the missing pages but she was warned that if there was a further incident of unacceptable behaviour, she would be moved to the segregation unit. Ms Landsberg's cell was searched for the missing pages from her ASBIP book. Although the missing pages were not found, the search found four bed sheets and a television aerial, which she should not have had. Later that afternoon Ms Landsberg told her tutor that she had torn pages from her ASBIP book and thrown them down a toilet.

48. On 30 August, Ms Landsberg received a negative IEP comment for disturbing her education class and for being rude. Due her accumulated negative ASBIP entries Ms Landsberg was raised to 'immediate risk' on a scale of negative behaviour including behaviour impacting on the maintenance of good order or discipline (Prison Rule 45) with a maximum sanction of relocation to the segregation unit. Ms Landsberg was segregated that afternoon with a review date of 2 September.

49. A nurse completed an initial segregation health screen that day and noted that Ms Landsberg would be able to 'cope' with a period in segregation. She did not refer to the potential drug overdoses that Ms Landsberg's had taken in June and July and instead noted that Ms Landsberg had not self-harmed during her period in custody. The nurse completed a further segregation health screen on 1 September and also failed to note the potential drug overdoses.

50. On 31 August, the Head of Female Prison noted that Ms Landsberg was being extremely disruptive and she was warned that she would remain in the segregation unit until her behaviour improved.

51. All the staff in the segregation unit told the investigator that Ms Landsberg had generally been disruptive: she used her cell bell inappropriately and frequently demanded medication, even when she had already received it. In her use of force statement (completed after Ms Landsberg had been restrained on 2 September) an officer recorded that Ms Landsberg misused her cell bell in the segregation unit, telling staff that she had dizzy spells and could not walk when they opened the door, although she was seen to move about normally when she did not know staff were observing her. Another officer made a similar comment in her use of force statement and described Ms Landsberg as constantly wasting staff time, pushing boundaries and making every task harder that it need be.

52. Although Ms Landsberg had a large physique, none of the officers said they felt intimidated by her.

2 September

53. At 5.50pm on 2 September, a nurse went to Ms Landsberg's cell with Officer A to give her medication. Officer B joined them as Officer A wanted to open the cell door so Ms Landsberg would have to take her medication in front of staff and would not try to conceal it as she had done the previous evening. Both officers recorded in their use of force statements that, when they opened the door, Ms Landsberg "deliberately" fell to the floor. Officer B recorded that Ms Landsberg said that her legs did not work, although the officer said she was moving her legs around on the floor and reaching for the sink. Both officers said that Ms Landsberg had thrown herself on the floor on numerous previous occasions. After they tried unsuccessfully to persuade her to get up and to take her medication, they locked the door and walked away.

54. They returned to Ms Landsberg's cell a few minutes later to try again to give her medication. Officer B said in her use of force statement that when they opened the door, Ms Landsberg was still on the floor where she had been lying. The nurse tried to help her stand up but without success and Officer A instructed her to stand up, but Ms Landsberg was not listening. Ms Landsberg then started to try to wriggle out of the door.

55. Officer A said in her use of force statement that when they unlocked the cell this time, Ms Landsberg resisted the nurse's attempts to get her to stand up and then threw herself backwards from a sitting position onto the floor. She began to edge out of the cell and resisted efforts to pull her back into the cell.

56. The nurse told the investigator that Ms Landsberg did not say anything or shout during the incident, although she thought she was making some sound.

57. Both officers said that as they tried to shut the cell door, Ms Landsberg was in the way and took hold of Officer B's legs and that they therefore decided that they needed to use force to get her back in the cell. They asked the nurse to leave the cell and Officer A pressed her personal alarm. They moved Ms Landsberg back into the cell with difficulty, as she was "grabbing hold of things" and was a large woman, and they rolled her over from her back to her front.

58. When a Supervising Officer (SO) arrived in response to the alarm, he took control of Ms Landsberg's legs as she was kicking out at staff. He then placed her in a 'figure of four leg lock' and the officers left the cell and locked the door. (A figure of four leg lock is an approved Control and Restraint technique used to allow staff to leave a cell safely after restraining a violent prisoner. It involves placing the prisoner in a prone – face down – position and bending their arms and legs up behind them. The last officer to leave the cell then presses down on the prisoner's limbs to push themselves up and back out of the cell. It is likely to be painful but should not cause injury.)

59. The incident was not filmed as Officer A had earlier removed her body-worn camera as she said she had not anticipated using it before the end of her shift.

60. Both Officer A and the nurse told the investigator that, as far as they were aware, Ms Landsberg did not hit her head during the incident, although the nurse said she was not in the cell when the officers were restraining Ms Landsberg.

61. The nurse said she did not enter the cell to examine Ms Landsberg after the restraint. She tried to check through the observation panel in the cell door to see if Ms Landsberg had received an injury during the restraint but noted on the medical report form that Ms Landsberg declined to engage in conversation and did not say she needed treatment. She told the investigator that Ms Landsberg, she was lying on the floor on her front. She did not say anything but she was making noises and moving her hands.

62. Officer A said that she checked Ms Landsberg two or three times between 6.30pm and 7.30pm when her shift ended. She said that at one point Ms Landsberg was sitting on the floor and then she was lying on the floor. As this had been typical behaviour for Ms Landsberg, it had not given her any cause for concern. She also said that it was not uncommon for prisoners to stay on the floor after a use of force incident. She briefed the oncoming night officer, Officer C, about what had happened.

63. Officer C told the investigator that after receiving a handover she checked all the prisoners in the unit. She noted that Ms Landsberg was lying on the floor and was clearly breathing. She continued to check Ms Landsberg through the night and noted that she had seen her moving and also that she was mumbling to herself at times. She said that she had not been concerned as it was not unusual for Ms Landsberg to lie on the floor and for her to mumble or talk to herself. (Ms Landsberg's records contain several previous instances where she was noted to be lying on her cell floor, either speaking or mumbling to herself.)

3 September

64. At 7.30am on 3 September, Nurse A went to the segregation unit to issue morning medication. She was told that officers had restrained Ms Landsberg the previous evening and that she had been lying on the floor ever since. She said that she knocked on Ms Landsberg's door and opened the cell door observation panel. Ms Landsberg was mumbling to herself and did not engage with her. She said that she was not concerned as this was normal behaviour for Ms Landsberg. She added that Ms Landsberg was due to receive an iron tablet for anaemia deficiency and there was no risk if she missed this dose.

65. Officer A arrived in the unit at around 8.00am to join Officer B. Although she understood that Ms Landsberg had slept on the floor all night, she said she knew that a nurse had seen her that morning and that no concerns had been raised. She said that she went into Ms Landsberg's cell at 8.20am and placed her breakfast tray on the basin.

66. At 10.00am, the duty manager made a routine daily visit to the segregation unit to check all the prisoners. He told the investigator that he received a briefing from the staff before visiting each prisoner. He went into Ms Landsberg's cell where she was lying on the floor and mumbling to herself. The officers told him that a nurse had seen her that morning and had raised no concerns. He asked the officers to contact the healthcare unit for her to be checked again. He then

re-read Ms Landsberg's daily record, which confirmed that a nurse had seen her that morning. He said that the previous day's records for all the prisoners had been filed away so that the only records available were for the current day. He said that he was unaware that Ms Landsberg had been lying on her cell floor since the previous evening.

67. Officer D told the investigator that by the late morning, the officers were becoming concerned that Ms Landsberg was still on the floor. Officer B telephoned Nurse A and Officer D made an entry in the observation book:

> *"11.05am: [Nurse] contacted as Ms Landsberg is still lying on the floor since last night. [Nurse] is happy that Ms Landsberg is just attention seeking and faking medical issues."*

68. Officer D said that Nurse A added that she would be coming to the unit at midday to issue lunchtime medication. (At interview, the nurse said that she could not recall receiving this telephone call and she denied that she would refer to a prisoner as 'attention-seeking'.)

69. Officer A said that she took Ms Landsberg's lunch tray to her cell at 11.45am. She placed the tray inside the cell and noticed that Ms Landsberg had not touched her breakfast. She said that this did not cause her concern as many prisoners left their breakfast untouched. She went on her lunch break after this. (The officers did not see Ms Landsberg eat or drink from the time she began lying on the floor although she was seen to have a bottle of undiluted cordial in the cell.)

70. Nurse A went to the segregation unit at 12.00 noon to issue lunchtime medication. She said that she went to Ms Landsberg's cell and when she looked through the observation hatch, it seemed to her that Ms Landsberg was lying in a different position to how she had been in the morning. She said she tried to speak to Ms Landsberg but she was snoring, so she decided to let her sleep. She said that she did not want to risk going into the cell to examine Ms Landsberg as she feared being assaulted.

71. Officer D was the only officer on the unit when Nurse A visited. When her colleagues returned from their lunch break, she briefed them about what had happened and, based on the nurse's assessment, they were all content that there were no concerns with Ms Landsberg.

72. Officer A said that at around 2.40pm, she and Officer B noticed a strong smell of urine coming from Ms Landsberg's cell and they saw a wet patch on the cell floor. They went into the cell to observe Ms Landsberg more clearly and then telephoned Nurse A to ask her to come to the unit. After a few minutes, Officer B telephoned the Segregation Supervising Officer (SO), to report to him what had been happening with Ms Landsberg. (The SO had been working in the healthcare unit that day.)

73. Nurse A arrived at about 2.45pm and went into Ms Landsberg's cell with Officers A and B. She said that she pushed Ms Landsberg's foot with her own foot and could feel resistance. She told Ms Landsberg to stop messing around and then threw some water on her to provoke a reaction. Ms Landsberg did not react, so

the nurse left the cell and told the officers that Ms Landsberg would probably wait for her to leave the unit and would then start knocking on her door.

74. The SO said that after Officer B telephoned him, he went to the segregation unit to find out what was happening. He heard Nurse A talking to Ms Landsberg in the cell in a raised voice and, when he went to see what was happening, the officers told him that the nurse had thrown a cup of water over Ms Landsberg. The nurse then left the unit. The SO said that he would have expected the nurse to have done some medical observations. He then returned to the healthcare unit to speak to a senior nurse.

75. The senior nurse said that when the SO returned to the healthcare unit, he asked her whether Ms Landsberg's clinical observations (pulse, temperature and respiration) should be checked. She wondered why Nurse A had not made clinical observations, but decided that she would do them herself. When she reached the unit, the officers told her that Ms Landsberg had been "playing around" lying on the floor since the previous evening. She said the atmosphere was "jokey". She told the officers to unlock the door and she went into the cell. Ms Landsberg was lying on her back, mumbling and playing with her fingers. She asked for a torch so she could examine Ms Landsberg properly. She checked Ms Landsberg's blood pressure, her blood/oxygen level, her blood/sugar level and her eyes. She told the officers that Ms Landsberg was extremely ill and to call an ambulance. The ambulance call was made at 3.13pm and paramedics arrived ten minutes later. Ms Landsberg was taken to hospital and placed in intensive care, where she remained from that time onwards.

76. Due to her clinical condition, Ms Landsberg had been sent to hospital with two escort officers, but without restraints. However, her hospital escort risk assessment noted that during a previous hospital escort she had been restrained twice due her erratic behaviour, so if her condition improved the need for restraints would have to be reviewed. At 8.10pm, one of the bedwatch officers noted that Ms Landsberg had partially woken and was becoming restless, so they applied an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). There is no indication that the officers spoke to a nurse or doctor before applying the escort chain.

77. Peterborough's Head of Performance had already spoken to Ms Landsberg's family but she wanted to update the family, so she went to the hospital at about 9.30pm to check Ms Landsberg's condition. She spoke to a doctor and then contacted the prison's duty senior manager to discuss the use of restraints. The duty senior manager said that the escort chain should be removed. She told the escorting staff to remove the escort chain and told them that if they later believed it might need to be reapplied, they should first speak to a doctor and then telephone the duty manager for advice.

Contact with Ms Landsberg's family

78. The Head of Performance telephoned Ms Landsberg's sister in the early evening of 3 September to tell her that Ms Landsberg was in hospital and was critically ill. After going to the hospital at 9.30pm, she was able to update Ms Landsberg's sister with the news from the hospital that Ms Landsberg had stabilised. As her

sister lived around three hours away from the hospital and had a young family, they agreed that she would update her in the morning.

79. The Head of Performance visited the hospital on the morning of 4 September, and was told that the family should be advised to visit. She telephoned Ms Landsberg's sister and she came to the hospital later that day. Other family members visited on 5 September. Ms Landsberg's sister was with her when she died at 4.56pm on 6 September.

80. Ms Landsberg's funeral was delayed due to the need for specialist post-mortem investigations. Once held, the prison contributed to the costs in line with national policy.

Support for prisoners and staff

81. The Head of Female Prison debriefed staff after Ms Landsberg's death to ensure that they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

82. The prison posted notices informing other prisoners of Ms Landsberg's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Landsberg's death.

Action taken by Sodexo Justice Services

83. On 7 September, Nurse A was suspended from duty and she remained suspended until she was dismissed without notice on 30 January 2018.

Post-mortem report

84. Ms Landsberg's post-mortem report gave her cause of death as multi-organ failure, caused by diabetic ketoacidosis, rhabdomyolysis and aspiration pneumonia.

85. Diabetic ketoacidosis is a complication for people with diabetes and occurs when the body starts to run out of insulin. Rhabdomyolysis is the breakdown of muscle cells, resulting in their contents being released into the blood which is toxic to the kidneys. A well-recognised cause of rhabdomyolysis is lying for a long time on a hard surface. The post-mortem examination found evidence of aspiration of stomach contents into the lungs. The pathologist noted that Ms Landsberg had had incidents of aspiration during intubation while in hospital, but noted that aspiration could also have occurred while she was lying on her cell floor in prison.

86. The pathologist concluded that the potential consumption of large quantities of an undiluted sugary drink was likely to have contributed to the development of diabetic ketoacidosis. The pathologist noted that it was not possible from the pathology alone to determine whether Ms Landsberg became unwell because of developing diabetic ketoacidosis which led to her lying on the floor of her cell, or whether she took to the floor for another reason and while lying there developed medical complications which ultimately led to her death.

Findings

Clinical care

87. The clinical reviewer focussed on Nurse A's actions on 3 September. She noted the nurse's belief was that Ms Landsberg was feigning illness and that she was apparently concerned that she might be at risk of assault from Ms Landsberg even though she had no history of violence. As a result, and despite security staff being available to protect her and restrain Ms Landsberg if necessary, she failed to take Ms Landsberg's clinical observations on each of the three occasions that she went to the unit that day.

88. The clinical reviewer has particularly criticised Nurse A's third and last interaction. By that stage, Ms Landsberg had been lying on her cell floor for 21 hours. She had only been observed to move minimally and she had been incontinent of urine. Although there were three officers on the unit, the nurse again chose not to take clinical observations but instead threw a cup of cold water on her. The clinical reviewer considered that the nurse's actions and omissions of care contravened the standards for practice and behaviour expected by the Nursing and Midwifery Council (NMC) and require further professional investigation.

89. The clinical reviewer noted that most of the nurses interviewed, including Nurse A, were unaware that Ms Landsberg had Type 2 diabetes because of a record-sharing restriction that had been made at HMP Send. The clinical reviewer noted that this omission in knowledge was not significant until Ms Landsberg became unwell while in the segregation unit. There is no evidence that she ate or drank during the 21 hours that she spent on her cell floor, other than that she might have drunk from the bottle of undiluted cordial. The clinical reviewer noted that Nurse A acknowledged at interview that she would have acted differently if she had been aware of Ms Landsberg's diagnosis. We understand that some of the healthcare staff at Peterborough would have had the necessary system permissions to determine which prison had set the restriction, and should have contacted them to have the restriction removed, provided Ms Landsberg consented.

90. The clinical reviewer is also critical of prescribing decisions at Peterborough. Ms Landsberg was noted to have an aspirin allergy but was nevertheless prescribed a non-steroidal anti-inflammatory drug (NSAID), which is a known contraindication for patients allergic to aspirin. In addition, Ms Landsberg was given medication in-possession despite indications that she was not suitable. She was also able to take a second overdose on 8 June when her medication was not confiscated, and she took a further overdose in July when again given medication in-possession. These potential overdoses were not noted when nurses completed their assessments on whether Ms Landsberg was fit for segregation: a history of drug overdoses might be an indication that a prisoner is at raised risk of self-harm and potentially unsuitable for segregation. The clinical reviewer has made a number of recommendations which the Head of Healthcare will need to address. In line with these, we make the following recommendations:

The Head of Healthcare should ensure that:

- **Nurse A is referred to the Nursing and Midwifery Council to consider her fitness to practise;**
- **staff understand how SystmOne record-sharing restrictions can be removed;**
- **the further learning needs for all the clinical practitioners named in the clinical review are reviewed; and**
- **thorough reviews about the healthcare capability at all levels, prescribing practices and diabetic care are conducted.**

The Director and Head of Healthcare should ensure that all medical staff who undertake segregation health screen assessments record incidents of potential self-harm properly and, in light of these, consider carefully the prisoner's suitability for segregation in line with Prison Service Order 1700.

Decision to segregate/operation of the segregation unit

91. We question the process through which Ms Landsberg came to be segregated. Her behaviour was being monitored through the ASBIP process in which IEP and other warnings were recorded. The process contains a four-scale assessment of the prisoner's risk to good order with the highest level of risk incorporating the potential sanction of relocation to the segregation unit.

92. We acknowledge that Ms Landsberg was a difficult prisoner to manage but are concerned that the interaction of the IEP, ASBIP and segregation processes may have led to a decision to segregate her which was not proportionate to the risk she posed to herself, others or the good order of the establishment.

93. We also note that Ms Landsberg was warned by the duty manager on 31 August that she would remain in segregation until there was a marked improvement in her behaviour. This was not a decision for the duty manager; a decision on Ms Landsberg's segregation would have been taken by a segregation review board if they had met on 2 September.

94. When Ms Landsberg initially lay down on her cell floor at 5.50pm on 2 September, it was not unreasonable for staff to view this as typical behaviour for her: the officers and nurses had all dealt with her in the past and had found her to be demanding and uncooperative.

95. However, while Ms Landsberg's actions might have been viewed as typical at the outset, there is no evidence that she had ever previously behaved in such a way for any period of time, let alone such an extended period of time, and the absence of any meaningful interaction or of a more questioning approach for such a long period in a segregation unit is unacceptable. Ms Landsberg remained lying on her cell floor for the next 21 hours and there is nothing to suggest that officers in the segregation unit wondered whether anything was wrong or made any effort to engage with her in a meaningful way. While staff noted that she was breathing and mumbling to herself, there is no evidence that they tried to speak to her. Nor did they seem concerned about Ms Landsberg's

fluid and food intake throughout this time: no one saw her drink, apart from the possibility that she might have drunk from a bottle of undiluted cordial and both her breakfast tray and midday meal were left untouched.

96. It is clear that the officers relied far too heavily on their past knowledge of Ms Landsberg, failed to question Nurse A's lack of concern and did not do enough either to query clearly troubling behaviour or to identify Ms Landsberg's seriously deteriorating condition. Although the segregation senior officer was deployed elsewhere on 3 September, his absence was not an excuse for the officers in the segregation unit to abdicate responsibility for ensuring basic safety. Indeed, the officers would have been able to contact him for guidance earlier on in the day or sought guidance from the duty manager, either when he visited the unit at 10.00am or at any other time during the day.

97. While we fully agree with the clinical reviewer's criticisms of Nurse A, we also consider that the segregation officers failed in their responsibilities and in their duty of care to Ms Landsberg, not least because she was constantly in their care rather than only intermittently so, as was the case with Nurse A.

98. We make the following recommendations:

The Director should review the use of segregation in the context of the interaction of the prison's ASBIP protocol, the Incentives and Earned Privileges scheme and the provisions of PSI 1700, in particular the principle that segregation should only be used as a last resort and that any decision to segregate a prisoner is entirely proportionate to the risk they pose.

The Director should ensure that segregation staff understand fully their responsibilities and, in particular, that:

- **staff selected to work in segregation have sufficient experience and training for the role;**
- **they engage with prisoners in a meaningful way and should record these interactions in the prisoners' history sheet;**
- **they brief the Duty Director fully about all significant events in the past 24 hours; and**
- **they recognise and understand the circumstances when they should seek managerial guidance about the prisoners in their care.**

The use of force

99. Staff used force on 2 September to place Ms Landsberg back in her cell after she tried to prevent staff closing the cell door. Ms Landsberg did not pose a serious risk of harm to the two officers when they initiated force, but they had already spent some time trying to persuade her to stand up and let them close the door and we accept that force was justified because she posed a threat to good order and control in the segregation unit. There was nothing at that point to suggest she was ill or that a proportionate use of force was inappropriate, and the post-mortem report did not suggest that she sustained any injury during the restraint.

100. However, we are critical that Ms Landsberg was not examined by a healthcare practitioner after the use of force to check her well-being. We do not consider

that a nurse's unsuccessful attempt to communicate with Ms Landsberg while peering through the cell door window amounted to an examination as required by PSO 1600. In our view, a member of healthcare should have been asked to examine Ms Landsberg later in any event, and particularly when she continued to lie on the floor and did not communicate with staff. We make the following recommendation:

The Director should ensure that where it is not possible for a healthcare practitioner to examine the prisoner safely immediately after a use of force incident, the prison should arrange for healthcare staff to visit again later when the prisoner has had a chance to calm down.

101. We are also critical that Officer A had removed her body-worn video camera that afternoon which means that the opportunity to capture potentially crucial evidence about the use of force was lost. Peterborough's protocol on BWVCs states that they should be worn at all times by assigned users. Although the officer told the investigator that she took the BWVC off because she was not expecting to open any cells at that time of the day, she took the decision to open Ms Landsberg's cell not just once but twice, and had time to put the BWVC on before doing so on both occasions.

102. We also note that PSI 04/2017 contains more detailed instructions on the use of BWVCs than that contained in Peterborough's protocol. We make the following recommendations:

The Director should review the local protocol on the use of body worn video cameras to ensure that officers do not remove their body-worn cameras until they have ended their shift.

The Director should review the local protocol on the use of body-worn video cameras to ensure that it accords with the instruction in PSI 04/2017.

Actions and inaction of the segregation officers

103. As set out above, we have significant concerns about the actions of the segregation officers during the extended period that Ms Landsberg was left lying on her cell floor. Despite any assurances they might have received from Nurse A, Ms Landsberg had no previous history of lying on her cell floor for an extended period of time, she had left her breakfast and lunch untouched and did not appear to have drunk anything. In these circumstances, we are troubled that the segregation officers did not appear concerned about Ms Landsberg's wellbeing. There was also some evidence of general jocularity among the officers until a senior nurse's intervention. We make the following recommendation:

The Director should commission a disciplinary investigation into the actions and inaction of the segregation officers who were responsible for Ms Landsberg's care on 2 and 3 September 2017.

Restraints, security and escorts

104. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

105. Ms Landsberg had been sent to hospital without restraints. Although we note that she was seriously ill at the time, we also note that she had a recorded history of inappropriate behaviour and the escorting officers did not know her. The bedwatch records show that she had started to become restless in hospital so the escorting staff, on their own initiative, applied an escort chain, even though she was at the time in the intensive care unit. However, we note that within around 90 minutes, the Head of Performance reviewed the use of restraints and, in collaboration with the Duty Director, authorised their removal. We make the following recommendation:

The Director should ensure that hospital escort staff take advice from an appropriate manager before applying handcuffs to a prisoner.

Liaison with Ms Landsberg's family

106. When the Head of Performance was appointed as family liaison officer, she made an initial telephone call to Ms Landsberg's sister and then visited Ms Landsberg in hospital to obtain more information about her condition. She then contacted Ms Landsberg's sister again to discuss whether she would need to travel to the hospital that night, taking into account the distance she would have to travel. She contacted Ms Landsberg's sister the next morning to update her and she travelled to the hospital later that day. Family members were with Ms Landsberg when she died.

107. We are satisfied that there was good, supportive liaison with Ms Landsberg's family, including informing them promptly of her admission to hospital and dealing in a sensitive and understanding way given the distance that Ms Landsberg's sister would have to travel to reach the hospital.

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