

**Investigation into the circumstances surrounding the  
death of a man at HMP Long Lartin in April 2007**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**December 2010**

This report considers the circumstances surrounding the death of a man at HMP Long Lartin. He was found hanging in his cell in the segregation unit at 8.30pm on 1 April 2007, having last been seen alive approximately one hour earlier. The man was a Muslim by religion. He had come to the UK while a young child as a refugee from Uganda. He was 21 years old. My sincere condolences are offered to the man's family for their loss.

My colleague led the investigation with the help of an assistant. I would like to thank the Governor of Long Lartin and the former Governor of HMP Belmarsh and their staff for their cooperation during this investigation. I am also grateful to Worcestershire Primary Care Trust (PCT), who produced a thorough clinical review of the care that the man received in custody.

I must apologise for the delay in issuing this report. The investigation was complex and lengthy. It was not until January 2008 when the last interview took place and the clinical review was submitted.

The man was a very complicated, disturbed young man with a long history of mental health problems and violence. He had been remanded into custody at HMP and YOI Chelmsford in October 2004, but was not sentenced until October 2006. Both before and during his time in custody, the man received numerous mental health assessments but was never conclusively diagnosed. Whilst in custody he was treated for depression and occasional psychotic symptoms – hearing voices. In 2005, the man spent four months in a medium secure hospital for assessment. However, he proved difficult to assess. His symptoms were not consistent with any one diagnosis, he was violent and inferred that he was feigning illness to receive a lighter custodial sentence.

In December 2005, after seriously assaulting staff at the hospital, the man was returned to HMP Belmarsh. His behaviour was tempestuous and he often resorted to further violence. Eventually, the man was deemed to be completely unmanageable in prison healthcare facilities or in any main prison wing. As a consequence, he was placed in Belmarsh's segregation unit. He remained segregated (first at Belmarsh, then at Long Lartin) from August 2006 until his death.

Whilst in segregation the man's behaviour continued to deteriorate. He was disruptive, refused to engage with staff, would not comply with simple requests, held dirty protests, attacked staff, was verbally abusive and sexually inappropriate. Mental health teams and discipline staff were at a loss as to how to manage his care. The man was referred to Broadmoor high secure hospital on several occasions. Each time he was deemed not unwell enough for admission, but the situation would be kept under review.

The man was transferred to Long Lartin in October 2006. On 2 March 2007, after five months of segregation at Long Lartin, the man was referred to the close supervision centre (CSC) system for those prisoners who appear unmanageable elsewhere in the prison estate. His referral had not been considered before he died on 1 April. Despite the man's bizarre and erratic behaviour, he had never given any cause for staff to believe that he was a real risk to himself.

There are other similar prisoners in the prison system. Prisoners who are not diagnosed with a severe and enduring mental illness, yet are difficult to care for adequately as they present challenging behaviour and symptoms. Despite the increased mental health support in prisons in recent years, there are still insufficient resources to deal with the need. Many prisoners suffer from personality disorders that are judged as not treatable. Prison mental health teams and discipline staff largely manage such prisoners, as they are not suitable candidates for in-reach care or secure hospitals. Due to erratic, difficult and sometimes violent behaviour, they often end up being segregated.

As I have said in all too many reports following deaths in custody, segregation units are not suitable environments for the vulnerable or mentally ill. The regime is limited and isolating, 24 hour healthcare support is not provided and officers are not trained psychiatric nurses. Such placements are not fair to the prisoners or to staff. However, in the absence of suitable alternative accommodation or transfer to secure hospitals, there is often no other option for a Governor except transferring the problem to another prison.

Between April 2004 and 1 April 2007, my office investigated 28 self-inflicted deaths in segregation units. (Including this death.) HMP Long Lartin had three self-inflicted deaths in 2007, two of which were in the segregation unit and involved young men with demanding mental health needs. During the investigation into the second death, staff in the segregation unit reported an increased mental health team presence since the man's death. However, there are still clear gaps in the mental health resources available to Long Lartin, and these require serious attention. I sincerely hope that lessons will be learned from both deaths.

I have not been able to conclude whether the man's actions were a cry for help or intentional. I am confident that staff in both Belmarsh and Long Lartin responded appropriately to the man's immediate needs given the resources available at the time. However, I have commented on the management of his longer-term needs and made ten recommendations for improvement in mental healthcare provision, the segregation unit regime and transfer between prisons.

The sad facts outlined in this long report may be summarised as follows. This man came to this country as a young child to escape the ravages in Uganda. From an early age, his behaviour was highly disturbed and while still a teenager he was convicted of manslaughter. In prison, his behaviour was both challenging and dangerous, but he was not generally felt to have a treatable mental illness. He spent long periods in segregation, and was frequently subject to use of force. At the age of 21, he took his own life.

All too often, we seem to have nowhere to care for people like this man except in the segregation units of high security prisons.

**Jane Webb**  
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## SUMMARY

This man, a Muslim prisoner originally from Uganda, was brought into custody on 23 October 2004, aged 19. He was subsequently convicted of manslaughter. He had a long history of depression and anti-social behaviour. On being remanded to HMP and YOI Chelmsford, a suicide and self-harm monitoring form was opened as the man had told the police he was at risk to himself. He thought “the spirit of Harry Potter” possessed him. A psychiatrist reviewed the man and found no evidence of mental illness. He was placed on normal location in the prison, pending further assessment.

In custody, the man was subject to frequent observation by mental health teams and psychiatrists. Independent experts undertook psychiatric assessments in preparation for his court case to determine whether the man could be detained under the 1983 Mental Health Act. The man described hearing voices and tapping noises. Psychiatrists were unable to agree on a diagnosis of psychotic disorder. It was concluded that he was not unwell enough to be detained under the Mental Health Act.

In January 2005, the man tried to hang himself. He said that he did this because the voices had told him to kill himself. After psychiatric review, he was diagnosed as having experienced a psychotic episode. The man was referred to a medium secure psychiatric hospital (John Howard Centre, JHC) for further assessment. After an initial assessment on 13 April 2005, he was placed on a waiting list. A referral was also made to Broadmoor, a high secure psychiatric hospital. Whilst on the waiting list, the man transferred from Chelmsford to HMP Belmarsh on 28 June 2005.

He was admitted to JHC on 10 August 2005. During the initial period of assessment he believed other patients wanted to kill him. Nursing staff found that, despite his apparently distressing symptoms, the man appeared relaxed and not perplexed. He ate, socialised well and was often seen to be cheerful.

Later that year during a drug free trial in November 2005, the man inferred that he exaggerated his illness. He feared a long prison sentence and thought that if he was found unwell it might result in a lighter punishment.

The man’s behaviour escalated and became increasingly violent. In December 2005, he grabbed a handful of tablets from the medication trolley and seriously assaulted three members of JHC staff. He said that the voices told him to do it, but later admitted he was angry that the staff did not believe that he was mentally ill and so had assaulted them. The man returned to HMP Belmarsh on 22 December where he continued to be monitored without medication.

The man progressed from the healthcare centre to living in a normal houseblock in late April 2006. This was short lived as he assaulted a fellow prisoner and was consequently located on the segregation unit for seven days. Although he then calmed down it was decided by the mental health in-reach team to refer him Broadmoor again. A referral was sent on 5 May.

A doctor from Broadmoor assessed the man on 6 June 2006. She concluded that he required further specialist assessment in a high secure hospital to exclude a mental illness. It was difficult to say with certainty that his paranoid delusions and hearing voices were completely fabricated as they were convincing at times. Nevertheless, the Broadmoor admissions panel decided in July not to offer him a bed at that time. It was concluded that he had been stable in a prison setting since November 2005 until July 2006. However, if he deteriorated and his instability recurred, Broadmoor would consider an urgent re-referral.

The man's erratic and violent behaviour continued and, as a consequence, he was frequently sent to the segregation unit. In the segregation unit he continued to receive mental health interventions but remained medication free.

On 13 August 2006, the man attacked a prisoner and an officer. He was moved to the segregation unit by force and placed on a multi-officer unlock with staff wearing personal protective equipment. This meant that more than one officer had to be present to unlock his cell, and all officers had to wear protective clothing. These measures were put in place to minimise the possibility of a further assault. Three days later, the man attacked another member of staff, punching him in the face. He was to remain on the segregation unit with the same unlock protocol. The man attributed his deteriorating behaviour to not taking medication. The mental health team could find no justification for restarting any medication as, despite his behaviour, he did not display any psychotic symptoms.

The man's interactions with staff become less frequent. When he did communicate it was abusive and sexually inappropriate. He continued to be violent, blocked off his observation panel so staff could not see him and initiated dirty protests. (This is when a prisoner defecates or urinates in their cell. It often involves smearing faeces on the walls, clothes or themselves and throwing urine out of the cell.) On occasions when he became physically violent or tried to break away from staff, he would be placed in a special cell to calm down.

This behaviour continued throughout September 2006. An entry in the segregation unit log records that the man was overhead telling another prisoner that the way to avoid serving a life sentence was by being found mentally ill. Two days later he threatened to kill an officer.

The man received a life sentence on 12 October and was to serve a minimum of 12 years. The judge's sentencing remarks concluded that the man did not qualify for a hospital order under the Mental Health Act 1983 and he was to serve his sentence in prison. He returned to Belmarsh.

On 16 October 2006, a request for a transfer to the segregation unit of another prison was made. Such transfers are only made in exceptional circumstances as it is desirable that prisoners progress from segregation units back to the main prison. The request was made due to the man's relentless disruptive and violent behaviour. The Governor of HMP Long Lartin agreed to accept the man. I comment in this report on the transfer process. Healthcare staff at Long Lartin were not fully briefed of the man's circumstances before he moved prisons. I have made a

recommendation that the Governor at Long Lartin should ensure all staff are fully briefed before receiving a prisoner with a history of mental illness.

Another recommendation for Belmarsh concerns the fact that there is no record of the man being told of his transfer. He should have been informed in accordance with Prison Service Order 1700.

The man transferred to Long Lartin on 20 October 2006 and was placed in the segregation unit. Despite a short period of calm, his behaviour deteriorated and he became increasingly withdrawn. He was violent and abusive towards staff, engaged in more frequent and prolonged periods of dirty protest and was a constant disruption on the unit. The man drummed or banged on his door or other surfaces in his cell, persistently flushed the toilet or ran the taps. Other prisoners on the wing became unsettled and threatened disruptive behaviour of their own or to self-harm in order to stop him. He was often placed in one of the special cells, by use of force, to defuse confrontational situations. I have judged that the use of force was appropriate. However, there were occasions when relevant documents were not completed soon after an incident. I have asked the Governor at Long Lartin to remind staff to check and sign such documents at the earliest opportunity.

In addition to these violent and abusive acts, the man's behaviour was bizarre. He built a den out of his cell furniture and would hide from staff. When not in his den he would place a towel or piece of clothing over his head to hide his face. The man often refused to speak and would shut his eyes when he came out of his cell. Staff would have to guide him around the wing.

Despite this strange behaviour, this man remained difficult to diagnose and did not demonstrate consistent symptoms indicating a psychotic illness. His medication was briefly restarted, but he did not comply with his prescription and refused to take the medication after a couple of days.

The man received mental healthcare at various stages from the primary mental health team, the in-reach team and a visiting psychiatrist from the Reaside Clinic. (The clinic is a medium secure psychiatric hospital with outpatient facilities that supports the mental health team at Long Lartin.) I comment in this report on how the different mental healthcare teams relate to each other. During the course of the investigation it was not always clear who had clinical responsibility for the man. I recommend that the Head of Healthcare reminds staff to keep a clear record of the transfer of clinical responsibility between primary and in-reach teams, and to keep a record when responsibility is shared between the teams.

I also comment on the mental health resources available to the segregation unit. Based on my findings and the suggestion of staff, I recommend that Worcestershire Primary Care Trust and the Governor at Long Lartin allocate the equivalent of a full-time registered mental health nurse to the unit. Segregation unit staff want a better understanding of the prisoners in their care, and I recommend that consideration be given to including the segregation unit manager at the weekly mental health team meetings. In addition, I recommend access to mental health awareness training with regular updates for all segregation unit staff.

The visiting psychiatrist was concerned that the man might be psychotic so he referred him to Broadmoor for assessment. This assessment took place on 22 December 2006 and concluded that the man suffered from an anti-social personality disorder and not a psychotic illness. The man's history of fabricating psychotic symptoms was noted. Doctors at Broadmoor again concluded that The man did not meet the criteria for admission, but he should continue to be monitored and the decision would be reassessed in two to three months time.

The mental health teams and segregation unit staff tried to engage with the man, but he consistently refused. On occasion, he would talk to the imam, a member of the Independent Monitoring Board, a probation officer and one of the governors. Between them, they succeeded in getting the man to agree to a simple care plan to help him progress out of the segregation unit. However, his engagement was shortlived and progress was very limited.

In March 2007, after five months in the segregation unit, a referral was submitted to the close supervision centre (CSC) system. (The CSC system specialises in managing disruptive and violent prisoners who are unmanageable within the normal prison system and are unable to progress out of segregation.) I comment on the timeliness of this submission. Prisoners at Long Lartin who remain on the segregation unit for three months should be reviewed with a view to the next steps. I believe that consideration should have been given to the man's referral after three months rather than five.

The man's behaviour improved during March 2007. He was quiet at night and compliant with staff. The segregation review board noted that the man had "made a complete turnaround – no knocking no violence". He was making positive progress. Sadly, this changed on 26 March when he flooded his cell. Two days later he started a dirty protest and stopped communicating with staff. There were no obvious triggers for his change in behaviour.

On 30 March, the imam appealed to the man to stop his dirty protest and he agreed to do so during the afternoon of Sunday 1 April. At 5.00pm, after showering, he moved to a clean cell and received his dinner. The man was found hanging in his cell at 8.20pm when night staff came on duty and performed the evening roll check. Despite attempts by staff to resuscitate him, the man was pronounced dead at 9.00pm by paramedics.

The man was very concerned about appearing mentally ill. There is evidence of him lashing out and becoming more violent during periods of uncertainty or when his medication was reduced or withdrawn. This fuelled fears that he was feigning symptoms to be considered mentally ill and avoid a lengthy life sentence. There seems to be no question that the man suffered from a personality disorder. However, personality disorders are not generally regarded as treatable with medication. A person suffering from a personality disorder needs to engage with support mechanisms and staff in order to improve. This man was unwilling to engage despite numerous attempts to help him, particularly at Long Lartin.

It has not been possible to conclude whether the man intended to kill himself. Both the clinical reviewer and I are confident that staff in both Belmarsh and Long Lartin

acted appropriately given the resources available to manage the immediate needs of a prisoner like this man. I question whether early intervention could have been made to secure the management of his longer-term needs. The segregation unit is not a suitable place to address and assess the mental health needs of an individual. Neither is it a favourable environment for progressing prisoners through the system those who are clearly not able or willing to engage. I have recommended areas for improvement in mental healthcare provision, the segregation unit regime and transfer between prisons.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 2 April 2007 by one of my investigators. She discussed the circumstances surrounding the man's death with the Deputy Governor at HMP Long Lartin. My investigator arranged to attend the prison to collect all paperwork relating to the man's time in custody and to receive a full briefing.
2. On 4 April, My investigator met the deputy governor, a principal officer, representatives from the Prison Officers' Association, and the member of the Independent Monitoring Board at Long Lartin who was on duty the day the man died. Long Lartin's then newly appointed Governor, was not available during this visit.
3. My investigator and her colleague conducted interviews at Long Lartin in two sessions. In addition Worcestershire Primary Care Trust provided a clinical review of the care the man received during his time in custody. The clinical element of the investigation has resulted in a considerable delay in publishing this report. My investigator was only able to interview head of mental health at HMP Belmarsh, in January 2008. However, it was imperative for the information to be included in my report as the handling of the man's time in custody was heavily influenced by his mental health.
4. Notice of the investigation attracted prisoners' attention. My investigator and her assistant received six letters with information suggesting staff misconduct prior to the man's death. Several prisoners requested meetings with my investigators. Those who were still at Long Lartin during the course of the investigation were spoken to and my investigator travelled to HMP Whitemoor to meet one other. My investigators found the allegations of wrongdoing to be unfounded.
5. CCTV footage from the segregation unit was available for the evening that the man died. Unfortunately, the format of the footage could only be viewed using equipment on the unit and could not be converted into a different format to be viewed elsewhere. The police viewed the footage as part of their investigation and confirmed that details given in witness statements were accurate. Based on police findings my investigator did not watch the footage. My investigator did ask to see CCTV footage from February 2007 when a complaint was made against an officer for his treatment of this man. This footage was not available as the tapes used are recorded over after a period of time.
6. One of my family liaison officers contacted the man's family. She spoke to the man's uncle. He asked that a thorough review of the man's mental health care take place. The family were aware that the man had considerable mental health issues and are keen to know whether his care was appropriate. The family did not rule out a meeting with the investigator after my draft report was issued.

## **HMP LONG LARTIN**

5. HMP Long Lartin is a high security prison. It holds some of the most serious offenders in the prison system.

### **Accommodation**

6. The prison has an operational capacity of 492. There are seven main residential units and a detainee unit. All cells are for single occupancy.
7. The segregation unit is attached to Perrie wing, which is the largest residential unit at Long Lartin, holding 120 prisoners. The other main units each hold up to 77 prisoners. All residential units have toilet and shower facilities on every landing. The Perrie wing and the segregation unit benefit from in-cell sanitation whereas the others do not.

### **Segregation Unit**

8. The segregation unit has 38 cells. The unit includes a holding facility comprising four cells for prisoners awaiting transfer to a close supervision centre (CSC) unit, or who have been moved from a CSC to give staff respite. The segregation unit has two special cells used for de-escalating violent or confrontational incidents, such as an assault. The special cells have CCTV cameras to enable constant supervision. They have no furniture aside from a raised plinth for a bed. The cells are only used in extreme circumstances and prisoners should remain in them only for as long as it takes to calm down.
9. The unit has an enclosed exercise area. The education department provides some in-cell support and there are daily visits by a governor, member of the Independent Monitoring Board (IMB), chaplain and doctor. Adjudications are normally held in the morning on a daily basis, except for Sundays and public holidays.

### **Regime**

10. Long Lartin provides a regime designed to offer prisoners a choice of rehabilitative activities. These include charity and contract work, where prisoners work in busy activity areas assembling plumbing equipment and light fittings for commercial companies, earning enhanced wages. In addition, there is a range of vocational and educational training opportunities. All activity areas are developing accreditation as a key part of the regime to enhance prisoners' opportunity for employment upon release, as well as providing settlement to long-term offenders.
11. During time spent in the segregation unit, prisoners do not typically have access to these activities if they are segregated for reasons of "Good Order and Discipline" (GOOD). However, any improvement in behaviour is rewarded by a return to normal location. Over the past year, access to exercise and education has been improved and a good proportion of segregated prisoners make use of them. Some exercise equipment is set up in one of the special cells once a

week. An induction booklet, which provides guidance on in-cell exercises, is given to all prisoners on entry to the unit.

## **Healthcare**

12. A multi-disciplinary team of nurses employed by Worcestershire Primary Care Trust staff the healthcare centre. The GPs are employed through by Trust via an agency.
13. Three teams provide mental healthcare – the primary care mental health nurses, a mental health in-reach team (MHIRT) and forensic psychiatric services provided by the Reaside Clinic. A prisoner is triaged by primary care on reception to prison. If there is a history of mental illness or evidence of a severe and enduring mental illness, the prisoner is referred to the MHIRT and, where necessary, a psychiatrist. The primary care team manages any prisoner displaying other mental health problems, such as depression or a personality disorder.
14. The MHIRT is a small team comprising a manager who is a registered mental health nurse (RMN), a full time community psychiatric nurse (CPN), a part-time occupational therapist and an administrator. The team feeds into primary care through multidisciplinary team meetings and provides wing-based services. As the team is small, the time spent with prisoners is limited. Clients are seen weekly or fortnightly, dependent on their need.
15. The Reaside Clinic, the largest National Health Service medium secure unit and part of Birmingham and Solihull Mental Health Trust, provides regular input from forensic psychiatric mental health professionals. As well as providing acute in-patient and rehabilitation beds, the clinic has a community outreach service. This service is extended to prisoners at Long Lartin. As with the MHIRT, the level of psychiatric support is dictated by an individual's need. The psychiatrists attend the prison on a weekly basis as well as taking part in the multi-disciplinary meetings.

## **Chaplaincy**

16. The prison has a chaplaincy team made up of three full-time and a number of part-time and sessional chaplains in the multi-faith team. There are two chapels and a range of multi-faith rooms. The chaplaincy team provides pastoral care for staff and prisoners alike. A member of the chaplaincy team visits all prisoners on the segregation unit every day.

## KEY EVENTS

### HMP Chelmsford

17. The man was arrested by Barking Police on 23 October 2004 and remanded into custody at HMP and YOI Chelmsford two days later. Due to the nature of his offence and information supplied by the police, the man was immediately placed on a suicide and self-harm watch. Whilst in police custody, the man had expressed the intention to commit suicide and appeared depressed. Prison reception staff acknowledged this and a member of healthcare who conducted the man's initial health screen assessment opened a suicide and self-harm monitoring form (F2052SH). (This form was then in use to monitor and observe a prisoner at regular intervals.)
18. A prison doctor saw the man the following day (26 October) on the induction wing. The man again denied any suicidal ideation, but did state that he had a history of depression. He said that he had not taken any anti-depressants for six months. Although he showed no signs of mental illness during this meeting, the doctor referred him to a psychiatrist, prescribed five days supply of zopiclone (a sleeping tablet), and recommended that he be admitted to the healthcare centre for further observation.
19. On 29 October, a second visiting psychiatrist met the man. They discussed his depression. The man reported that his last anti-depressant did not work and he wanted mirtazapine (another type of anti-depressant). This visiting psychiatrist did not think that the man needed to be kept on the healthcare unit and said he was fit to move to a normal wing, but would be subject to further mental health assessment and observation.
20. The man moved to a single cell on normal location. A cell sharing risk assessment took place. Based on his history of violence and possible mental health issues, the man was appropriately deemed unsuitable to share a cell. Two days later a doctor saw the man for review. He requested anti-depressants and said that he was not happy. The doctor did not consider the man to be clinically depressed, but nevertheless restarted his medication. He prescribed Zispin (a brand name for mirtazapine) at 15mg for one week increasing to 30mg for the following three weeks.
21. On 10 November, after only ten days on the wing, the man transferred to another wing because he had been fighting with another prisoner. The following day he was reviewed by the mental health team - two psychiatrists and a community psychiatric nurse (CPN). The team noted that he was not suicidal but the man had disclosed that he was hearing voices. The man was prescribed 10mg of olanzapine (an antipsychotic), told to stop taking the Zispin and was moved to healthcare.
22. Seven days later, the man was interviewed by a consultant forensic psychiatrist employed by his defence legal team in preparation for his trial. On examination, the consultant forensic psychiatrist found the man to have symptoms of clinical depression as well as hearing voices and paranoid

delusions. The consultant forensic psychiatrist recommended that the man be considered for referral to a secure hospital for treatment and assessment under Section 48 of the Mental Health Act 1983.

23. The second visiting psychiatrist established contact with the catchment area psychiatrist. They discussed referring the man to a medium secure hospital and it was agreed that he should be referred on 29 November. Over the next month, both the second visiting psychiatrist and the psychiatrist for the catchment area saw the man. His presentation did not change, but he had started to sleep better and, at intervals, stated that he had stopped hearing voices and a constant tapping noise. The man's olanzapine was doubled to 20mg.
24. The second visiting psychiatrist reviewed the man on 4 January 2005. He found him to have improved and thought him no longer sufficiently unwell to be sectioned under the Mental Health Act. Accordingly, the second visiting psychiatrist telephoned the man's solicitors and informed them that he would no longer be referring the man to a medium secure hospital as originally planned. The second visiting psychiatrist gave a possible diagnosis of paranoid schizophrenia.
25. Two weeks later, during a session with the second visiting psychiatrist, the man said that the voices and tapping had returned and were worse than before. He also said that he thought about suicide, but had no intention of acting upon his thoughts. The man asked to be moved back to normal location as he was bored in healthcare. It was agreed that he could return to the wing but had to come back to healthcare if there were any problems.
26. On 27 January 2005, an officer found the man attempting to hang himself using a bedsheet. The man said that he heard voices telling him to kill himself or another prisoner. He was re-admitted to the healthcare centre for observation and referred to the mental health team. A suicide and self-harm monitoring form (F2052SH) was opened to record the man's behaviour. The first entry on the form states that the man "is obviously mentally ill and needs the appropriate care and assessment". It is not possible to tell from the man's records when the previous F2052SH had been closed.
27. The second visiting psychiatrist saw the man the following day. He noted that the man was psychotic and recommended that he remain in healthcare. The decision was taken to refer the man for transfer to a secure hospital. A formal referral letter with background information on the man was sent to the psychiatrist for the catchment area to identify an appropriate medium secure hospital. In the meantime, a preliminary psychiatric report was given to the court indicating that the man was not fit to plead and he was being referred to be sectioned under the Mental Health Act. His anti-depressant was changed to trazodone.
28. A series of enquiries were made during March to find a suitable medium secure hospital. On 8 April, the man was referred to the John Howard Centre (JHC) in East London. A few days later (13 April 2005), an appointment was made to

assess the man at Chelmsford prison. The man was compliant during this assessment. The following day, his self-harm and suicide form was closed as he was no longer considered to be at risk.

29. On 13 May, the man was placed on the waiting list for admission to the JHC. He was sixth or seventh on the list. The man continued to display symptoms of depression and heard voices. However, he was calmer in demeanour. The man asked if his medication could be changed so that he could further improve, but the second visiting psychologist advised him of the risks of adjusting his prescription. It was agreed that he should continue with his existing medications.
30. The man remained on the waiting list for transfer to hospital throughout June. On 28 June 2005, he was moved from HMP Chelmsford to HMP Belmarsh, an adult male prison. On reception at Belmarsh, the man was assessed by one of the prison psychiatrists. The prison psychiatrist discussed his mental health both prior to and during custody. The man explained about hearing voices and said that he did not feel safe at Belmarsh. The voices were telling him that the officers would tie him up. The prison psychiatrists decided that the man should remain in healthcare and that a suicide and self-harm form should be opened to monitor any risk. The prison psychiatrists recommended trying a different antipsychotic medication (aripiprazole). He also said that he would follow up the position regarding the transfer with the JHC and let them know that the man had moved to Belmarsh.
31. The man was continuously monitored by the mental health team during July. There was no change noted in his mental state. A care plan was drawn up on 10 July. He was encouraged to attend the Cass Unit (mental health day care centre) and to interact with other prisoners. A week later, during a review with the mental health team, the man explained that he heard voices that gave him basic instructions such as "turn left, turn right". They also told him to harm himself. The man said that he used the television to distract himself from hearing them. He remained in healthcare and his antipsychotic medication was increased by 5mg.
32. The man was admitted to the JHC on 10 August. During the initial period of assessment at the centre, the man consistently reported hearing voices that told him to harm others or himself. Examples included that he would say was that he was the "Devil's son" and that the voices had told him to jump into a fire. He also said that he believed other patients in the ward wanted to kill him. The man said that the devil was controlling people around him and wanted to burn or rape him. Despite this, he said that he was "able to resist the voices". He was prescribed lorazepam (sedative) and haloperidol (antipsychotic) and appeared more settled after taking his medication.
33. Nursing staff found that, despite his apparently distressing symptoms, the man appeared relaxed, was eating and did not appear perplexed. He began to socialise with others on the ward and was often seen to be cheerful. However, he did express annoyance at the close supervision by staff. By 20 August, the man reported that he was "no longer hearing voices all of the time, only

occasionally in the morning and late at night". The voice he heard continued to be that of the devil, the same voice he heard at the time of his offence.

34. A couple of days later, the man said that the voices had gone. He began to discuss his anxieties and said that he did not think the hospital could do anything to help him. He still felt frightened of other patients and had difficulty trusting staff. By early September 2005, the man said that the voices had returned, telling him not to eat or the voices "would kill all new born babies". He repeated that he was the devil's son and would kill everybody. On 13 September, he asked to see his psychiatric notes as he was concerned about the inferences being drawn from them. He expressed anxieties about being sent to a high security prison or "in a worst case scenario, returned back to prison."
35. The man's aripiprazole and anti-depressant medication were increased on 27 September. During early October, he developed difficulties with group activities and started staring at individuals. He talked to staff about violent fantasies and was often caught with pornography or inappropriate DVDs.
36. On 8 November, the doctor that assumed clinical responsibility for the man's care. As there were still uncertainties about his diagnosis she decided that he warranted a drug free trial. Over the next few days, the man reported that the voices were coming back and he attributed this to stopping his medication. His behaviour escalated and became increasingly sexually inappropriate and violent. On 18 November, he was seen by a clinical psychologist and spoke about the voices making him anxious and sad. The voices were stronger in the mornings. When he was in communal areas they told him to become evil and make sacrifices.
37. Two days later, at 10.40pm, the man complained of hearing voices and kicked and broke the door to the staff room. He said that he was not responsible for his actions and that the voices told him to kick doors. Shortly afterwards, he grabbed a handful of tablets from the medication trolley and attempted to swallow them. The nursing staff managed to remove the medication and he was given an intramuscular sedative. The man told staff that he did this because "it was the only way that I could kill myself". He later changed this account and said it was in response to the voices.
38. On 22 November 2005, the man again said that he heard voices. He demanded to see the doctor and have medication. He began pacing around the ward and complained that he was not having his needs met. The multidisciplinary team was uncertain as to whether he was suffering from mental illness or feigning sickness. The man appeared agitated and started kicking the walls, blaming the voices. He was advised to play some music and calm down, which he did.
39. The following day, the man was interviewed by an occupational therapist who said that he did not appear to be distracted. This was pointed out to him in relation to his claims of hearing voices, at which point he paused and replied "What did you say? – I'm sorry, the voices are distracting me." Over the next

few days he became increasingly aggressive, knocking down shelves in group areas, saying that he was distracted by the voices and attributing his behaviour to his medication being stopped. He talked about hearing a tapping noise at night and thought it was a ghost. The man also said that he thought that the staff were spitting in his food and planning to rape him. He asked to resume his medication as it had previously reduced the intensity of the voices. The man requested that the nursing level of observation be reduced, despite it initially being increased at his request, as he felt vulnerable.

40. Over the next week, the man appeared more settled. On 9 December 2005, an MRI brain scan was organised to rule out any organic reason for his behaviour. (It should be noted the scan did not take place as he was recalled to Belmarsh.) A consultant psychiatrist visited the man on 14 December to undertake an assessment on behalf of the court. The man later told staff that this consultant psychiatrist had indicated that staff doubted the authenticity of his symptoms. Afterwards, the man notably started to disengage with staff and became withdrawn. Concerns were raised that disengagement could potentially be a risk to staff on the ward.
41. On 15 December, the man told staff that he would not be able to cope in prison without medication. At 3.30pm the following day, the man was seen lying under his bed. He had closed the observation window to the room and gave monosyllabic replies when staff tried to call him. Forty minutes later he was seen punching and kicking nurses. Attempts were made to restrain him, but he assaulted these staff too. The emergency nursing team were summoned and the man was placed in seclusion at 4.30pm. On being spoken to by a doctor, the man said that the voices had told him to behave in this way. He was given a sedative and remained in seclusion.
42. Two days later on 17 December, the man paced his room and banged on the walls. He wanted to be taken out of seclusion and said that the voices made him behave this way and he would not attack again. The man continued to take sedative medication. Using the cord from his tracksuit he tried to self-harm. It was removed and he was again restrained. He admitted the following day that he entertained suicidal thoughts because he was facing a long prison sentence. The man said that he was angry about not being believed to be mentally ill.
43. The doctor responsible for the man's clinical care undertook a seclusion review on 22 December. It was noted that the man appeared angry when discussing his attack on staff. He was keen to know how long he would be detained in the future. This doctor found no evidence of psychosis or depression. The man was consequently moved back to Belmarsh with no diagnosis.
44. On return to prison, the man went back to the healthcare centre for a period of assessment. The cell sharing risk assessment paperwork completed on reception indicated that in the previous month the man had attempted to commit suicide by overdose. In response to this information, and although the man said he did not feel suicidal, a F2052SH was opened to monitor him.

45. A psychiatric review took place the following day. The man explained that he still heard the voices and they made him feel frightened and paranoid. The psychiatrist noted that the man appeared poorly groomed, thinner (107kg on transfer and now 85kg) and distracted. He was distressed and low in mood because of the voices, which also kept him from sleeping. There were no signs of intention to self-harm or commit suicide at this time. This doctor noted that the man might have a psychotic illness but further observation would be required to properly diagnose. It was decided that the man should stay in the healthcare unit and remain medication free until the mental health team management round. The man was given some sleeping tablets and recommended for weekly weighing to monitor his weight loss.
46. The man gained 4kg in weight that week, began using the exercise yard and would play pool with other prisoners during association. Aside from this, he shied away from interaction with other people and still reported hearing voices. The mental health team continued to observe the man whilst awaiting a discharge report from the JHC.
47. The man became aggressive on 29 December, injuring his right hand by punching his cell door. He said that he did it because the voices had told him to. The man also said that the prisoner in the next cell was making so much noise which was adding to his stress. He moved cells and was later seen by one of the psychiatrists. On seeing the psychiatrist, he became very animated when talking about the voices and requested medication. The man told the psychiatrist that he was angry that his medication had been stopped in the first place. He became quite distressed when he was told that the antipsychotic medication would not be prescribed until the JHC provided a full discharge summary. The man seemed to settle down. His F2052SH was closed the following day after a review concluded that he did not present as a risk to himself. The man agreed that if he felt like harming himself he would immediately tell staff.
48. The man's behaviour deteriorated on 3 January 2006 when he seriously attacked a fellow prisoner. He was restrained by officers and taken back to his cell where he was placed on a multi-officer unlock – a senior officer (SO) and three officers. This meant that a senior officer and three officers had to be present when he was unlocked. The man had to stand at the back of the cell until told he could move forward. He would then receive a rub down search before being moved to the back of the cell to be handcuffed. With an officer either side supporting him, he would then be moved to the exercise yard, showers and other areas. Visits would take place in the middle floor of healthcare. His handcuffs would be removed in the exercise yard, but he could not be there with other prisoners.
49. A nurse later spoke to the man about the attack. He said that the prisoner in the cell next door had been racially abusive towards him and continually tapped the cell wall for 24 hours a day. This was causing him distress. His claim was not investigated because it was the man who was tapping in his own cell.

50. The mental health team saw the man as part of the management round on 5 January. During this session it was noted that a consultant from the JHC would attend the following day but this visit did not take place. The mental health team decided on a working diagnosis of severe dangerous personality disorder. The next entry in the man's medical record is on 9 January. He was still on a multi-officer unlock and so was spoken to by the nurse through the cell door. The man said that he was still distressed by the voices and felt low in mood. On a scale of "one to ten" he said that his mood was a "four". By 11 January 2006, he had settled down, but the unlocking arrangements remained in place as well as an intermittent watch. For the next week the man continued to be nursed without medication. He reported that he was still hearing the voices but the tapping noise had stopped. The unlock protocol remained in place due to the man's unpredictability.
51. The doctor responsible for clinical care from the JHC visited the man on 19 January. She commented in his medical record that his recent attack on a prisoner was clearly impulsive and that he was an angry man. The man told her that the voices had become lower and he had not heard the tapping noise for three days. This doctor noted that the man believed that he was ill and wanted his medication restarted. When asked, the man said that he did not know how he would cope if he was given a long sentence – "maybe I killed myself. I don't know". This doctor also noted that the man's accounts of his experiences did not seem to match his presentation, although his recent actions had been violent and were possibly psychologically driven. Her recommendations were that she would discuss her assessment with the mental health team and consider a referral to Broadmoor (a high secure hospital).
52. The discharge review from the JHC, sent on 20 January, concluded that the man did not display any overt psychosis. Whilst at JHC, the man had admitted to exaggerating the voices because, prior to being transferred, a fellow prisoner had told him "even if you have voices they send you back". The man said that he did have voices but felt the need to exaggerate them to validate his illness.
53. The man remained as an in-patient in healthcare under the same unlock protocol. On 30 January, he started a cell fire because he was "bored". Over the next few days he settled down, but appeared flat in mood and unable to motivate himself. Responses to staff were only monosyllabic.
54. The JHC did not provide feedback to the mental health team about the doctor responsible for the clinical care's visit until 23 February, some four weeks later. It was decided, based on the last assessment, that they would not support a referral to Broadmoor.
55. By late February, the man was no longer thought to pose an unpredictable threat to staff and his multi-officer unlock was stopped. He appeared in court on 17 March. After this appearance he reported feeling lower in mood and had suicidal thoughts. He said that he heard voices, but they were not as bad as they used to be. One of the prison psychiatrists noted that the man appeared generally settled and had no thoughts of self-harm or suicide.

56. The man remained settled until 20 March when he demanded medication. When he was asked what kind of medication, the man said “anti-psychotics”. On being told it could not be prescribed as he would need to see the doctor, the man asked for anti-depressants. Again, it was stressed that they could not be prescribed by anyone other than a doctor and an appointment would need to be made. Although the man insisted that he was unwell and low in mood, it was noted in his medical record that he was smiling throughout and talkative.
57. There is no reference to the man seeing a psychiatrist until 4 April, when he saw the prison psychiatrist and again asked to be prescribed his medication. The prison psychiatrist said that he would not prescribe an anti-depressant as the man showed no signs of depression. An entry in his medical record the next day, regarding his care plan review, also shows that the man was not displaying any evidence of depression. He was seen to be eating, drinking and sleeping well, taking care of his appearance and there was no evident intention of risk of self-harm or suicidal ideation.
58. The man seemed to be generally stable throughout April. The John Howard Centre was asked by the court to form an opinion whether the man should be referred to Broadmoor under the Mental Health Act. The request was made in preparation for the man’s next court appearance on 27 April. In the run up to this date, the man appeared anxious and he told the prison psychiatrist that he no longer felt comfortable in the healthcare centre. He believed that staff knew about his offence and would tell the other prisoners. It was decided that he could move to a house block (normal location) and, if there were any difficulties, he could apply to move to the vulnerable prisoners unit. The man was allocated to a cell on house block one (HB1).
59. On 1 May 2006, The man said that he had some concerns about noises in the other cells in the early hours of the morning. He talked about hearing voices and how he could not clearly hear what they were saying. The man asked for his medication to be resumed. Later that day, the man assaulted a prisoner on the wing. He was placed in the segregation unit for seven days cellular confinement, subject to a two man unlock with hourly observations. The man lost all his privileges. This meant that he was not allowed to buy any goods from the canteen (prison shop), but he was granted one legal phone call and one personal telephone call per week.
60. There are four possible reasons for segregation:
- Rule 45 - segregation for a prisoner’s own protection
  - Rule 45 - segregation for Good Order or Discipline
  - Rule 53 - segregation whilst awaiting adjudication
  - Rule 55 - cellular confinement following being found guilty at adjudication.

Prison Service Order 1700 on Segregation states:

“Prisoners are only segregated for reasons of Good Order or Discipline when there are reasonable grounds for believing that the prisoner’s

behaviour is likely to be so disruptive or cause disruption that keeping the prisoner on ordinary location is unsafe.”

Segregation for this reason should only occur when other options have been explored, such as transfer to another wing, closer supervision on ordinary location, or transfer to another establishment. The decision to segregate should not be taken lightly as the regime is restrictive. Segregation should take place for the minimum time it takes for the prisoner to modify their behaviour and be fit to return to normal location.

61. Within two hours of being placed in the segregation unit, a member of the healthcare team should conduct a risk assessment of the prisoner to see if he is physically or mentally ‘fit’ to be detained there. The prisoner is told both verbally and in writing why they have been segregated. An initial segregation review board is completed within 72 hours. Subsequent review boards are held regularly, but at least every 14 days.
62. The mental health in-reach team (MHIRT) reviewed the man in the segregation unit two days later (3 May 2006). The man explained to the team that if he had medication he would not “hit out and would be more controlled”. He complained of “perceptual abnormalities”, but was vague when he was asked to explain what he meant. The team concluded that the man’s presentation appeared calm and settled. He was not displaying any obvious psychotic symptoms and his speech was normal and logical. The entry in his medical record states, “IMP [impression] – nil signs of mental illness evident at time of interview. Keen to be viewed as mentally ill.” The plan was to continue monitoring him and review in five days time. Despite this period of relative calm, the head of mental health at HMP Belmarsh wrote to Broadmoor on 5 May referring the man for assessment.
63. On 8 May, the man’s period of cellular confinement came to an end and he returned to HB1. The MHIRT conducted a review with him later that day. The man appeared aloof. He said that he could hear banging noises from his cell and that his mental health was “not good”. The man also said that he could not understand why he had been in a single cell and refused to accept any responsibility for his recent violent behaviour. The MHIRT concluded that the man was still not displaying psychotic symptoms.
64. The man was next seen by the MHIRT on 18 May. By his time he had moved to house block two (HB2). It is not clear why he was moved. The man told the team he was feeling better and attributed this to knowing that the prisoner in the cell next to him had a laptop which accounted for the tapping noise. He also said that he kept his television on constantly to block out the noise. When asked, he still could not offer a detailed explanation as to why he considered himself mentally unwell. The MHIRT found it difficult to assess due to his inconsistent responses and found him to be overly fixated with hearing noises. Subsequent weekly MHIRT reviews resulted in similar conclusions. The man consistently presented as keen to be seen as unwell and not coping, however the team were unable to detect any actively psychotic behaviour.

65. On 6 June, the doctor from Broadmoor visited the man to assess him for possible admission. The man repeated that he had attacked staff at the JHC because they did not believe he was unwell. He said, "I was going to prison anyway; I thought that if I attacked them they would believe me." He said that at the time he did not believe that someone was trying to kill him. The man told this doctor that he believed that, if he was in hospital and not in prison, he might get out sooner. He went on to say that he had invented the majority of his symptoms in the JHC and that only 20-30 per cent of what he reported was true.
66. This doctor report on the man's mental health concluded that he fulfilled the criteria for antisocial personality disorder and possibly an autistic spectrum disorder. She said that the latter would require further specialist assessment. On the subject of the man feigning symptoms of mental illness, this doctor confirmed that, despite having returned to Belmarsh and being on normal location without medication, his condition had not deteriorated. It was difficult for this doctor to say with certainty that the man's paranoid delusions and auditory hallucinations were completely fabricated as they were convincing at times. However, the fact remained that the man had admitted to lying in order to avoid a long prison sentence.
67. It was this doctor's opinion that the man warranted further assessment in a high security setting to properly exclude a mental illness. If no mental illness was identified, then he could possibly be assessed by the Dangerous and Severe Personality Disorder service for appropriate placement there. Further to this, the doctor responsible for the clinical care (JHC) strongly considered that the man should be transferred from Belmarsh after sentencing as his level of violence towards staff might escalate if he realised that he was being assessed. The head of mental health at HMP Belmarsh questioned whether the man would be suitable for a Hybrid Order after a period of assessment under Section 28 of the Mental Health Act 1983. (A Hybrid Order allows a prisoner to serve his/her sentence in a secure hospital until they are fit to carry out their sentence in a prison environment.)
68. The weekly MHIRT reviews continued with no change in their assessment of the man. Although the man said that he felt he was getting worse, there was no evidence that this was the case. He remained medication free.
69. On 19 June 2006, a forensic social worker at Broadmoor, wrote a report for the Broadmoor Admissions Panel based on assessments submitted on referral by the head of mental health, the doctor at Broadmoor and the doctor responsible for clinical care. The forensic social worker concluded that the man was currently "settled" at Belmarsh and "participating appropriately in services offered to him". She wrote that the man appeared mentally stable, presented no cause for concern and had not taken any medication for some time. The forensic social worker found that his presentation did not meet the criteria for admission to Broadmoor and that "it would be detrimental to move him now". However, should his behaviour cause concern in the future he could be transferred to a high security hospital under the Mental Health Act for a full assessment. His risk to others was too high for medium security.

70. The same day, a member of the MHIRT filed a security intelligence report after their visit with the man. He had told a nurse that he proposed to “deal” with the prisoner in the cell adjacent over an incident involving a packet of crisps. The man was not considered to be bullying the other prisoner, but he was warned to modify his behaviour. The following day, after a fight with the aforementioned prisoner, the man was removed from HB2 by use of force and taken to the segregation unit. The man told segregation unit officers that the prisoner in the cell next to him was deliberately tapping on the pipes to irritate him. Following this, an officer later observed the man himself tapping on the pipes in his own cell.
71. On 22 June, the man was relocated to house block three (HB3). Staff found it increasingly difficult to engage with him during his MHIRT reviews. This was not because he was not fully engaging, but he refused to elaborate why he felt he was mentally ill and became defensive when challenged. The man admitted he was distrustful of people, including his own family. He said he wanted to change cells because of the noise and felt there were too many people around. The knocking or tapping noise only occurred when he was in his cell and nowhere else. The MHIRT had difficulty discerning whether this preoccupation with noise was genuine, particularly as segregation staff reported the man had been observed making tapping noises. The man continued to show no remorse or accept any responsibility for his violent outbursts. The same care plan continued with weekly reviews, no medication and following up with Broadmoor regarding the referral.
72. Broadmoor staff wrote to the head of mental health at Belmarsh on 21 July, informing him they declined the man’s referral. The Admissions Panel was “unanimous in their decision that they would not offer [the man] a bed”. However, should he deteriorate they were prepared to urgently reevaluate. Not enough convincing evidence had been presented to suggest he suffered a mental illness and his “stability in a prison settling since November 2005” meant there was little point in a further assessment at that time.
73. The man was told of Broadmoor’s decision on 27 July, to which he replied “I don’t care”. When asked how he was feeling, the man said that he was not well and offered nothing to qualify this. He was reassured by the MHIRT that, as always, if he needed further support he could attend the Cass unit (mental health day care). The man agreed but appeared uninterested. The MHIRT concluded that he should be discharged from their caseload and that he could attend the Cass unit for support.
74. Whilst on the Cass unit on 11 August, the man asked to see someone from the MHIRT. He was reluctant to say why at first, but then told the nurse that he felt he was relapsing and asked for anti-depressants. It was suggested he should see a doctor for a review on 14 August. This review does not appear in the man’s medical record.
75. The man was moved back to the segregation unit on 13 August for attacking a prisoner and an officer. The man grabbed the officer’s throat as he tried to

break up the fight with the prisoner. Officers then used force to move him and he was placed on a multi-officer unlock – one SO and four officer unlock in full personal protective equipment (PPE). (PPE comprises stab vests, arm protectors, knee protectors, helmet, gloves and – if required – one officer with a shield. The use of equipment is reserved for prisoners who present a high threat to staff.) The following day, the man was moved to a special cell on the segregation unit for a further assault on an officer. (Special cells are used in exceptional circumstances to defuse and de-escalate situations involving violent and disruptive prisoners in the segregation unit. The prisoner remains in this type of cell until he is sufficiently calm to come out.)

76. Two days later (16 August), the man assaulted another member of staff. He punched an officer in the face over a dispute about his property not being given to him. The man remained in the special cell until he had calmed down. An entry in the segregation log notes that the healthcare risk assessment concluded the man was fit to remain in the unit. The man told staff that he had been taken off his medication and could feel himself deteriorating.
77. The unlock protocol was reduced to an SO and three officers the following day. On 18 August, the man declined the opportunity to submit applications for taking a shower or exercise and refused his evening meal. He would not speak to any staff. The man's mood was changeable. His interactions with staff became less frequent and, on occasion, he stared blankly at officers, making his mood difficult to assess.
78. During the early hours of 24 August, the man was given a warning for smearing toothpaste over the observation panel in his cell door. Later that evening, he threw hot water through the door hatch at an officer. This resulted in an adjudication hearing the next morning at his cell door with a governor. The man continued to behave aggressively throughout the day and was argumentative when he was refused more hot water. His behaviour worsened on 26 August when he threw food out of the door hatch and attempted to punch an officer. Staff managed to close the hatch. The man continued to be verbally abusive and to kick his cell door. He was given a warning and his incentives and earned privileges level was reduced from standard to basic for a 28 day period.
79. The purpose of the incentives and earned privileges scheme is to encourage responsible behaviour. There are three tiers to the scheme:
  - Basic – prisoners are placed on basic if they fail to meet the requirements for standard. All prisoners on basic will continue to receive the entitlements laid down in prison rules in relation to visits, letters, telephone calls, provision of food and clothing etc, and any other minimum facilities provided locally for all prisoners, apart from those in segregation. They will continue to participate in normal regime activities, including work, education, treatment programmes and religious services, be allowed access to the prison shop, exercise and association, and attend offending behaviour programmes as necessary.

- Standard – prisoners on standard level will be provided with a greater volume of the allowances and facilities at basic level, plus any additional privileges available locally. Typically, they will include more frequent visits, more time for association and the provision of in-cell television. Standard level prisoners are also eligible for higher rates of pay for work, subject to those on the enhanced level being considered first for particular jobs, and a higher allowance of private cash.
- Enhanced – prisoners on enhanced level will receive the same privileges as those on standard level but in greater volume with additional visits. Where possible visits may take place in better surroundings with increased flexibility over times. Additional time for association may be provided (subject to local resources), more private cash and priority consideration for higher rates of pay.

On entering custody, all prisoners are placed on standard and this is reviewed within the first month.

80. The man's behaviour continued to deteriorate over the next week. He became increasingly abusive towards staff and spent time shouting and banging against his cell door trying to get officers to lower the hatch. Whenever the hatch was lowered he would try to physically attack officers. The man also frequently blocked his observation panel with toothpaste and toilet roll. There was a strong smell of faeces coming from his cell. On 1 September 2006, the man was logged as officially having started a dirty protest.
81. The Prison Service definition of a dirty protest is when a prisoner:
- “... chooses to defecate or urinate in a cell or a room without using the facilities provided. In virtually every case the walls, the floor or ceiling are usually affected. Some prisoners may choose to cover their clothing and their body with faecal waste.”
82. Such action may be undertaken as a protest, but might also be attributable to mental health problems. At the beginning of, and for the duration of the protest, a doctor regularly assesses the prisoner's mental state by speaking to the prisoner through their cell door. If there are any concerns about the prisoner's mental health, and/or if there is any record of previous mental health problems, the doctor must arrange for a specialist assessment to be undertaken as soon as possible.
83. As soon as a prisoner begins a dirty protest the unit or wing manager must be informed, along with the Governor, head of healthcare, security department and the Independent Monitoring Board. A dirty protest log is then opened. Every effort must be made by staff to ascertain the reasons for the protest and appropriate encouragement given to the prisoner to withdraw the threat or end the protest. The prisoner is asked every day if they want to come off the protest and move to a clean cell.

84. In this instance, wing staff informed healthcare of the man's dirty protest and a member of the MHIRT attended to assess his mental state. The man asked to see a psychiatrist. He was told that an appointment had already been provisionally planned with the head of mental health at HMP Belmarsh for 4 September. My investigator has not seen the dirty protest log for the period 1-4 September as it was not available. However, on 4 September the segregation log continues and notes that the man ended his protest at 2.20pm that day. He moved to a clean cell by 4.25pm. There is no record of a visit with the head of mental health in the man's medical record for the day.
85. The man became verbally offensive and sexually inappropriate towards staff. He was told his behaviour was unacceptable and asked to stop, but he continued. His behaviour deteriorated over the next few days, and included kicking his door for long periods and blocking his observation panel. The records show that officers warned the man and informed him that if he did not comply with staff instructions then he would not be given meals. (Despite this investigation being lengthy, officers at Belmarsh have not been interviewed, therefore this comment has not been explored further.) The man began to threaten officers, saying he would kill them. On 8 September, he was placed in one of the special cells for trying to break away and fight with staff during unlock. He remained in the cell for an hour and twenty minutes until he calmed down and agreed to return to his cell.
86. At 3.00am on 9 September, the man was heard talking to himself. It appeared that he believed he was speaking to his mother in his cell and asking her to leave. He became aggressive and began shouting and kicking his door because he could not make her leave. The man was again heard shouting during the evening. The following afternoon, the man was singing loudly, banging on his door and shouting "evil!" Other prisoners began to complain. When staff asked him what was wrong the man said, "The demons only listen to noise" and "If I'm told bang the door I will fucking bang the door." He then lifted his mattress and pretended to shoot an officer with an imaginary gun. The following day an adjudication hearing was held regarding the continuation of the man's dirty protest. His earnings were stopped for 82 days and he remained on a four man unlock with full PPE and a senior officer.
87. Between the dates of 2 and 13 September 2006 there is no record of the man being seen by a member of healthcare or the mental health team. However, there are segregation log entries for this period which note no change in his behaviour. An entry in the log on 11 September states he received a 'routine' community psychiatric nurse visit as part of his ongoing monitoring and because he had started another dirty protest. The entry says, "there is insufficient evidence to suggest acute psychotic experience."
88. The community psychiatric nurse next saw the man on 14 September. The man told the nurse that he was on a dirty protest "because it cost the prison a lot of money to clean it up" and "it was the only way the prison would take him seriously". He said that he was worried about receiving a long sentence if he was not given a hospital admission. The community psychiatric nurse noted

the plan was to continue monitoring him and offer support. The man ended his dirty protest the next day.

89. The man remained settled for five days until 19 September when he threw water over another governor during a management visit to the segregation unit. (A governor visits the unit on a daily basis and speaks to each prisoner.) The man later threw a bowl of urine over an officer and shouted racist abuse during the collection of his lunch dishes. He was later racially abusive and sexually inappropriate towards an officer. There is an entry in the segregation log at 4.55pm which notes that the man was overheard telling another prisoner how to avoid doing a life sentence by getting yourself “nuttled off” (meaning being found to be mentally unwell). Staff said that he continued to be disruptive and offensive for the rest of the evening and following day.
90. On 21 September, the man’s offensive and aggressive behaviour escalated and he threatened to kill an officer. The man blocked his observation panel, spat and threw water at officers when they opened the hatch. This behaviour continued over the next week with more threats against officers. The community psychiatric nurse saw him on 28 September for a routine CPN visit and found there was no evidence to suggest deteriorating mental health.
91. The man was scheduled to appear in court on 29 September. He was asked whether he wanted to appear in person and he replied he would rather have a video link. Forty minutes later he changed his mind and said that he would rather appear in person.
92. The disruptive behaviour continued. The man was abusive to staff, left his sink taps running (he said this brought him comfort), banged his door and blocked his observation panel. As a result, he remained on the basic level of the incentives and privileges regime. On being told to stop banging, the man said that it was another prisoner making the noise. He was also warned that, if he did not stop running the taps, his water would be switched off. On 3 October, the water was temporarily switched off in response to the man throwing hot water at an officer.
93. The man was due in court for sentencing on 12 October. He kept changing his mind about whether to appear in person or by video link. The custody management directions form for the court stated that he would require a six man unlock due to his “previously violent and unpredictable behaviour”, including attacks on staff and other prisoners. He eventually decided to attend in person.
94. The man was discharged to court and received a life sentence with a minimum term of 12 years. The sentencing remarks made by the Judge concluded that The man did not qualify for a hospital order under Sections 37 and 41 of the Mental Health Act 1983. He based his remarks on the findings of an assessment conducted by two doctors from Broadmoor in June 2006. Given the man’s own admission (whilst at the JHC) and expert opinion, it was concluded that he was feigning schizophrenia and exaggerating psychotic symptoms for personal gain. Despite this, it was acknowledged that he had

diminished responsibility for his actions due to a likely untreatable antisocial personality disorder. The man was to remain in prison custody and returned to the segregation unit at Belmarsh.

95. On 16 October, a request for the man to be transferred to another segregation unit within the high security estate was made by a governor at Belmarsh. Such transfers are only made in exceptional circumstances, as it is not generally deemed to be good practice to move a prisoner between the units. Ideally a prisoner should progress out of a segregation unit to normal location. The request was made due to the man's continuing bad behaviour and threat to others, including assaults to staff and prisoners. The man had numerous outstanding adjudication hearings for assaults on staff at Belmarsh that would be taken forward at Long Lartin. The governor at Long Lartin agreed to accept the man.
96. According to Prison Service Order 1700 on Segregation, prisoners (with the exception of Category A prisoners and those on the escape list) are normally told if they are being considered for a transfer to another establishment and to which prison they will be going. It is not documented anywhere whether the man was told of the planned transfer.

## **Long Lartin**

97. Six days later, on 20 October 2006, the man transferred to Long Lartin. On arrival, he was placed in a single cell on the segregation unit under the same unlock protocol – one SO and four officers. In accordance with the Prison Service requirements for moving to a segregation unit, an initial risk assessment took place. This and his unlock protocol were to be reviewed within 72 hours.
98. Unlike a normal reception into prison, the man had the prison regime and conditions explained to him in the segregation unit. (In routine circumstances he would have been taken through reception and placed in the induction wing.) An officer explained that he would receive canteen, visits, have access to showers and phones, 'in cell' education and religious services, exercise and a radio. However, he would not have access to a television, work, association periods or any handheld games. As before, the limited regime and reduced access to stimulating activity is part of the incentive to progress, improve behaviour and move off the segregation unit. The man was to remain in the unit for a period of three days for assessment to see if he could be located on the main residential unit.
99. Once on the segregation unit a registered mental health nurse saw the man. This nurse wrote in his medical record that he was unable to assess the man due to concerns about staff safety and the restrictive unlock protocol. He said that for the same reason he was unable to assess the man's physical state but would try over the weekend. This nurse noted from the man's medical record that he had a long psychiatric history. The man told this nurse that he had no

health concerns. The nurse thought that the man did not present as requiring immediate mental health intervention.

100. The following day, the registered mental health nurse assessed the man in the closed interview room on the segregation unit. The man was moved to the room by officers in full PPE kit -body armour, with a shield but no handcuffs. The nurse found the man to be open and lucid in conversation and had “no objective concerns about his mental state” at that time. The man said that he had not heard voices in six months and was not currently feeling any paranoia. He explained he had developed distraction techniques (like listening to the radio) to quieten the voices. However, the man did say that he had some trouble sleeping over the previous few days. The nurse noted from the man’s medical record that he had not taken any medication (aripiprazole, olanzapine and anti-depressants) for a year. The man told this nurse that, when he started to feel his mental health deteriorate, he would have trouble sleeping and would stop eating. The nurse made a note of this and decided that further monitoring would be required.
101. Although the registered mental health nurse was able to assess the man’s mental health, he was still not allowed to assess the man’s physical state due to staff concerns about safety. The nurse decided to refer the man for a psychiatric assessment and to the mental health in-reach team for discussion and to decide which team should be responsible for his care.
102. At Long Lartin there are three teams that provide mental healthcare – the primary care mental health nurses, a mental health in-reach team (MHIRT) and forensic psychiatric services provided by the Reaside Clinic. A prisoner is first assessed by primary care. The need for assessment is either identified by a member of healthcare staff or by a discipline officer. Any member of staff can make a referral. If there is a history of mental health illness, or evidence of a severe and enduring mental illness, the prisoner is referred to the MHIRT and, where necessary, to a psychiatrist. The primary care team manages any prisoner displaying other mental health problems not covered by the MHIRT such as depression or a personality disorder (which is largely considered untreatable by medication).
103. In his referral (submitted 23 October 2006), the registered mental health nurse explained that in his view the man had an interesting psychiatric history, a working diagnosis of Dangerous and Severe Personality Disorder and spoke about psychotic symptoms. However, he noted that the man did not display any current evidence of psychosis.
104. Later in the day, the chaplain saw the man as part of a routine visit for new prisoners. The man asked for his religious registration to be changed from Christian to Muslim, as he had been incorrectly listed. Following this meeting, a member of the prison’s Independent Monitoring Board (IMB) spoke to the man. It was noted by the IMB member that the man spoke quietly and respectfully and asked if he could have a shower. (It is part of the segregation unit routine that a member of both the chaplaincy and the IMB visit every prisoner on a daily basis.)

105. The man appeared to settle over the next few days. He requested a copy of the Qur'an and a radio. He also spoke to an officer about distance learning. The 72 hour segregation review board took place on 23 October. A governor told the man that, if he continued to comply with the regime and remained undistruptive, in seven days time they would consider removing the need for officers to use PPE when unlocking him. Until this time he would remain on the segregation unit.
106. On 25 October, during the duty governor visit to the segregation unit, the man asked if his current unlock protocol (the need for PPE) would be reviewed. He was told again that this would be considered in seven days if he continued to comply. The man again requested a copy of the Qur'an, along with a prayer mat and prayer beads. It is not clear when or whether all of these items were given to him.
107. The following day the man's behaviour deteriorated. From documentation, there appear to be no obvious triggers. He covered his observation panel with a piece of paper which read "Fuck off". When asked to remove it he said "Fuck off" and declined his meal. This continued the next day. A member of the primary care mental health team conducted a review with the man during the afternoon of 27 October after he had been restrained and placed in one of the special cells. He refused to tell the nurse if he had any injuries (although he did not appear to have any) and stood looking out of the window with his back to the cell door. The man was placed in the cell because he had refused to unblock the observation panel and obstructed staff entering his cell.
108. The special cells are located at the far end of the segregation unit and are behind a set of doors. Each cell is without furniture (but has a raised plinth for sleeping on) and is fitted with a CCTV for constant observation. In addition to the CCTV, a member of staff should check prisoners placed in the special cell every 15 minutes. It is not clear from the use of force management documents if this was done. It is also unclear whether the IMB was informed of the man's placement in a special cell. Prison Service Order 1700 requires that the IMB should be told within 24 hours of a prisoner being placed in the cell.
109. The next day, a specialist registrar in forensic psychiatry from Reaside Clinic, reviewed the man's mental health. As explained previously, Reaside is a NHS medium secure unit that provides psychiatric support to the mental health team at Long Lartin. The unit is part of the Birmingham and Solihull Mental Health Trust. This psychiatrist found it difficult to conduct the review as it had to be held at the man's cell door. The man told this psychiatrist that he felt officers were persecuting him and that he was being punished for defending himself. He said that he was "shocked" to have been moved to another segregation unit. The man also told the psychiatrist that he had manic depression because his "eyes were watering". During interview with my investigator, the psychiatrist explained that in psychiatric terminology the man's comment could be a thought disorder, which would be a psychotic symptom. The psychiatrist observed no signs of suicidal ideation or self-harm, but did think the man was paranoid. The action plan was:

- to gain a full psychiatric assessment in more appropriate conditions
  - contact Broadmoor to find out if there was an up to date plan of action on their part
  - consider his previous working diagnosis of personality disorder and monitor for possible psychotic episodes.
116. The man's disruptive behaviour towards staff continued over the next week. He repeatedly kicked his door and blocked the observation panel. A segregation review board took place on 31 October, chaired by a governor. The board concluded that the man should remain in the unit until he met the following behaviour targets:
- comply with unlock protocols
  - stop blocking the observation panel
  - stop attempting to assault staff.
117. An adjudication hearing was held on 2 November 2006 relating to one of the man's many postponed hearings at Belmarsh. (They had not been dealt with before he transferred.) This particular hearing related to an assault on an officer in Belmarsh. The man was found guilty and was punished with 21 days cellular confinement, 21 days of 50 per cent loss of earnings, and 21 days without canteen.
118. The psychiatrist saw the man for a follow up assessment after the hearing. The man told the psychiatrist that he felt paranoid and had trouble sleeping. He said he occasionally heard voices (both positive and negative) and sometimes saw his family's faces appear in pages of a book he was reading. The man said he felt low in mood, but tried to keep active in his cell as he had a lot of energy. They talked about his previous medications and how effective they had been. The man said he thought the aripiprazole (antipsychotic) had "worked okay". The psychiatrist concluded that the man did not demonstrate any thought disorder, but was difficult to judge as his presentation was inconsistent. The doctor's impression at the time was that the man might be a paranoid schizophrenic, but took into account the previous diagnosis of severe personality disorder. The psychiatrist resumed the man's medication and prescribed 30mg of aripiprazole, with a view to reviewing the situation in three weeks.
119. During the weekly multidisciplinary mental health clinic meeting on 6 November, the man's referral to the MHIRT was discussed. It was noted that his medication had been resumed to see if his presentation would improve. The registered mental health nurse wanted to discuss the possibility of admitting the man to healthcare for further assessment. However, due to his multi officer unlock protocol, it would not be feasible. Instead, the man would be seen more regularly in the segregation unit and this nurse would hold a joint assessment with a CPN from the in-reach team (MHIRT), as the man had now been referred to them. An appointment was scheduled for 7 November, however segregation unit staff cancelled this. The reason for the cancellation

was not documented. The appointment was rescheduled, but no date was given.

120. The man began a pattern of disruptive behaviour followed by periods of calm. He would bang and kick his door, cover his observation panel, spit at staff, attempt assaults and become very angry. Staff and prisoners described the banging as being more like endless drumming. He would quickly calm down and become quiet and hide in his cell, either by crouching down behind the door or making a tent to sit in using his furniture and bedding. His verbal communication was greatly reduced, almost monosyllabic, relying on persistent use of his cell bell or kicking the door to get staff attention for minor requests (such as shower gel).
121. On 17 November, The psychiatrist reviewed the man. He found the man pacing up and down his cell, tapping a water bottle with a towel covering his head. The man was unresponsive to the psychiatrist's efforts to engage and lay down on his bed, pulling the covers over his head. The psychiatrist noted that the man had refused to take his prescribed medication. The man said, "I want to get ill". The psychiatrist's impression was that his psychosis had possibly worsened and this might be due to schizophrenia or possibly substance misuse. (The prisoners on the segregation unit were known at times to have accessed illegal drugs.) The psychiatrist said that the man would be unlikely to cooperate with a urine drug test, so it remained a hypothesis. His action plan was to continue closely assessing the man and to refer him again to Broadmoor.
122. The man continued to disengage from all staff and disturb other prisoners on the unit. Despite efforts to persuade him to stop, he did not improve. He refused to make eye contact, communicated by hand gestures and hid under his bed. During a weekly segregation review board, a senior officer suggested that the man should be located in one of the close supervision cells (S111) as a furnished cell. There are no exposed pipes in the cell and the bed is a raised plinth. This would prevent him from banging on the pipes or hiding. This was agreed and the man was moved.
123. On 23 November, members from the MHIRT visited the man at his cell as per the registered mental health nurse's referral to their team in late October. The purpose of the visit was to see if the man qualified to become one of their cases. They observed him pacing his cell with a towel over his head. The man refused to engage in conversation and gave brief answers when questioned. He turned on his water taps and continued pacing. For a short time, he appeared to acknowledge their presence and agreed by hand gesture they could visit him again the following week. But when asked if he would show his face, he turned round in a circular motion and would not remove the towel. The man started banging his door and hid under his bed. This behaviour continued the next day.
124. On 29 November, a CPN from the in reach team visited the man. Again, he was reluctant to talk. He kept saying "goodbye" and stood behind his door, turned on the taps and repeatedly flushed the toilet. Segregation staff reported

to the CPN that the man had been eating and drinking and had been out on the exercise yard. They told her that he had been relocated to a CSC cell with a plinth under his bed to prevent him from hiding and to aid better observation. This CPN wrote in the man's medical record that the MHIRT would attempt to engage with him two to three times a week. They would also collate feedback from segregation unit staff and the psychiatrist.

125. The man's behaviour had not improved by his next review with the psychiatrist on 1 December. The man was unhappy because of his move to a CSC cell. He refused to leave his cell and kept a towel over his head throughout their conversation. The psychiatrist asked him why he was wearing the towel. The man replied, "It's not a crime is it?" Other than his behaviour, the man appeared to be coherent and he said that he had been eating and drinking. The man then ended their conversation. The psychiatrist made a note to continue pursuing a referral to Broadmoor.
126. The man continued to conceal his face using his clothing, was making dens with his blanket, was abusive to staff, and started another dirty protest. He refused to engage with the MHIRT, but was heard talking to other prisoners via the windows. Staff asked him if he wanted to end his dirty protest, but he refused to answer. He also declined some meals and switched on his water taps.
127. Members from the MHIRT periodically spoke to the man at his cell. On one occasion staff told them that he had been overheard talking to other prisoners and that he had been taking care of himself (showering, eating and drinking). The man agreed to speak to the MHIRT with the observation hatch open but a towel covering it and the taps running. He left a small gap in the hatch so that he could see them. The visit was terminated by the MHIRT with a view to continuing to try and engage twice weekly.
128. On 12 December, a governor chaired a segregation review board. All board members agreed that the man should remain segregated. The man declined to attend the board. His designated personal officer submitted the following statement to the board prior to their meeting:

"The man continues to display bizarre behaviour. He spends most of his time hidden under a blanket. He continues to disrupt the whole unit by keeping everyone awake by constantly banging his door making noise by any means. He refuses to interact with staff and communicates by making signs with his hands."
129. A personal officer is an officer who is responsible for a designated number of prisoners. Their duty is to speak to the prisoner, listen to any concerns, and provide support and assistance where possible. Any comments made by the man's personal officer were on the basis of observations and feedback from other members of staff. In this man's case, the personal officer scheme did not work effectively because he would not engage with staff.

130. The review board set further behavioural targets for the man to meet before he could move off the segregation unit:
- meet regularly with the imam
  - develop and adhere to an action plan for progressing his behaviour
  - come off the SO and four officer unlock.
131. The man's next review was set for 14 days time. The man received notification of this decision and was told that he was to remain on the unit because he was deemed to pose a risk to staff.
132. On 14 December, the MHIRT started preparing transfer papers to be sent to the Home Office in the event that Broadmoor would accept the man's admission following his imminent assessment. The following day, the psychiatrist saw the man for his regular review. Segregation staff told the psychiatrist that the man was behaving bizarrely, but was less violent. Some staff thought that his unlock protocol (a senior officer and four officers in full protective kit) could be reduced and a decision would be taken at the next review. It was also reported to the psychiatrist that the man was eating and drinking, and he had been heard talking lucidly to other prisoners during the night. The man refused to leave his cell to talk to the psychiatrist, so they conversed through the cell door. He did, however, keep his head uncovered. The man denied hearing voices, having visual hallucinations, disturbed sleeping patterns, racing thoughts or increased energy. He told the psychiatrist that he had no idea why he was being detained in the segregation unit as he had not been aggressive.
133. The man's behaviour improved over the next few days. The imam had been working with him, trying to get him to engage more positively with staff. The man stopped putting a blanket over his head and had conversations with the governors during their routine management rounds of the segregation unit. A senior officer noted in the man's history sheet that this was a "positive step". The man asked to end his dirty protest. He had a shower and moved to a clean cell.
134. On 19 December, after referral by the psychiatrist, a forensic psychiatrist from Broadmoor, telephoned the CPN to arrange an assessment on 22 December. Two days later, the CPN spoke with the man during her routine MHIRT visit. Prior to speaking to the man, segregation unit staff told her that his behaviour was improved; he was now engaging in conversation and was no longer hiding under his bed. The plan was to review his unlock protocol if this improvement continued.
135. The CPN introduced herself to the man and reminded him that she had been visiting him for the last few weeks. He declined to come out of his cell to speak with her and remained at the door. She asked him why he was no longer wearing the towel on his head. He said that he had been "messing around and was now being serious". The man told the CPN that his thoughts were "crystal clear" and that he had been eating and drinking, attending to his personal care and going on the exercise yard. He reiterated that he had no idea why he was

being detained on the segregation unit. The man agreed to speak to her again in the near future.

136. The forensic psychologist from Broadmoor visit took place at 11.00am on 22 December. The man refused to go to the interview room and was assessed at his cell door. The forensic psychologist found that the man was more communicative and his behaviour less abnormal. He was not wearing a towel over his face and had been speaking to other prisoners. The man told the doctor that he had no current problems and that his previous disclosures and abnormal behaviour were just “messaging around”. He denied having any mental illness.
137. The forensic psychologist recorded that the man appeared “neat, clean and relaxed” and was “alert, orientated and his concentration was okay”. His impression of the man was that he was currently normal, had a history of fabricating psychotic symptoms and had an antisocial personality disorder. The forensic psychologist wrote that the man, “will almost certainly require [a] Broadmoor admission assessment at some stage in the future. Admission at this stage [was] unlikely to yield much.” He suggested that the man’s mental state should be monitored in the short to medium-term as additional assessments would be needed for further consideration. The forensic psychologist said that, if possible, psychotropic medication should be avoided. The Broadmoor Admission Panel would provide a report of the visit.
138. Two days later, on Christmas Eve 2006, the man’s behaviour deteriorated. Another prisoner on the wing caused a disturbance and the man in. He lay on the floor of his cell and kicked the Perspex panel at the front of his sink until it came off. He also tried to break the glass panel in the cell door. When questioned about his actions, the man said he was “smashing it up”. A principal officer was informed about his behaviour and he instructed staff to shut off the man’s water supply until he calmed down.
139. A segregation review board was held on 27 December. A senior officer noted that the imam had continued to work hard with the man. He was beginning to show signs of improvement and was moved out of cell S111 and back into a cell with a proper bed. The unlock protocol was to remain the same for the time being, but there was hope that staff could stop using the full protective equipment (PPE). This would be reviewed at the next board. In the meantime, behaviour targets were set for interacting properly with staff and complying with the regime. The man was told of the board’s decision – that his behaviour remained unfit to move to normal location in the prison.
140. During the daytime on 29 December, it was noted during a routine MHIRT visit that the man had calmed down and was being compliant. However, he was disruptive on New Year’s Eve and segregation unit staff updated the CPN from the inreach team on the man’s behaviour. They also told her that when he was moved from his cell he would not maintain eye contact and laughed to himself. During her review, the man refused to acknowledge the CPN’s presence. He placed a towel over his head and stood by the window. She continued to try and get him to engage, but he refused to talk.

141. That night the man banged and kicked his cell door, refusing to stop for 20 minutes. An entry in his history sheet states that a prisoner in an adjacent cell goaded the man to “get the sink off, that really upsets them”. Moments after, staff observed the man trying to smash the sink off the wall and kicking the panel below the sink. Wing staff sought advice from a principal officer (PO) on duty, who said to turn off the water supply to the man’s cell. The duty governor was informed of the situation. The man gave up banging an hour later.
142. The officer initiated the anti-bullying strategy in case the prisoner goading the man was bullying him. Attempts were made to talk to the man, but he would not engage in conversation. The man was advised he could speak to the chaplaincy, Samaritans or a Listener (a prisoner trained by the Samaritans) if he wanted to. The other prisoner was relocated to a cell away from the man. Staff continued to monitor the situation but there was no further evidence to suggest that the man had been or was being bullied. The anti-bullying procedure was closed ten days later.
143. The man’s kicking and banging in his cell continued, as did his lack of communication with wing staff other than to shout abuse. He declined to go to the exercise yard (a small cordoned off concrete area outside the segregation unit where prisoners can be outside, but in isolation) and refused to shower. The man blocked off his observation panel and covered his face with his towel.
144. On 3 January 2007, the man moved cells as he had damaged his current cell and continued to block off the observation panel. Once moved, he began smashing up his sink. The man was told to calm down. Later in the day he was seen by the imam to discuss his behaviour. The man told the imam he kept on “getting interference from staff, which had made him go back to his current situation”. The imam wrote an entry in the man’s history sheet that suggested he be given some distance to allow him “to break the mental block but [he was] not sure how to achieve this”.
145. A member from the Home Office telephoned the MHIRT on 4 January for an update on the man’s referral to Broadmoor. She was informed by the MHIRT secretary that the forensic psychiatrist had assessed the man, but from looking at his medical record no decision had yet been made.
146. The man continued to keep his observation panel blocked and to bang on his cell door. The banging and drumming was constant and disturbed everyone on the wing. Staff told the man that he would not be given toilet paper and soap until he stopped blocking his observation panel. This was because the man used these items to cover the glass.
147. Every day a member of the IMB, the imam and a duty governor saw the man. In particular, the imam was able to foster a more positive relationship than most staff with the man and was able to encourage him to converse. The imam and one of the duty governors sat with the man and prepared a four-week action plan to try and improve his behaviour and move him back to normal location. They set small goals that they thought were manageable – no blocking his

observation panel, not kicking the door, to stop drumming and banging, and to interact with staff. The aim was to try and instil some sense of normality.

148. On 8 January 2007, a multi-disciplinary mental health team meeting discussed the man. It was agreed that he should be discharged from the MHIRT's care and that the primary care mental health team should continue to work with him. The registered mental health nurse agreed to continue monitoring the man. No clear reason is documented in his medical record for this shift in case management.
149. The man's aunt contacted the prison through a detective sergeant of the Metropolitan Police. She had been trying to visit the man but was unable to do so as he would not complete and send out a visiting order. His aunt asked for regular updates on his wellbeing from the prison through the man's offender manager. She also asked for a visit to be arranged.
150. The man's home offender manager came to Long Lartin on 8 January. He was attending a multi-agency lifer risk-assessment panel (MALRAP) meeting at the prison about the man. Following the meeting, the offender manager accompanied the man's home offender manager to the segregation unit where he met the man for the first time. He was introduced to the man at his cell door. The offender manager told my investigator that the man spoke to his home offender manager and "seemed to respond to his authoritative, but kindly tones". She said, "this interaction may have been more successful as the man's home offender manager is a mature black male". The home offender manager said he would contact the man's family for him and, if he was agreeable, would return to see him again in a couple of months. Despite this positive interaction, by the next day the man had slipped back into his previous behaviour. He was abusive and sexually inappropriate towards staff and refused to take any application request forms.
151. The psychiatrist decided that the man needed to be more closely monitored and have all observations clearly documented. A period of closer assessment was needed to ascertain whether his behaviour had sufficiently deteriorated to warrant another referral to Broadmoor. It was decided between the primary care mental health team and wing staff that the Assessment, Care in Custody and Teamwork (ACCT) form could be adapted to do this. (The ACCT form replaced the F2052SH form and is used to monitor prisoners at risk of self-harm or suicide. It is not a clinical document. The form has adequate space for making detailed entries and continued observations. Any member of staff can make an entry on the form.)
152. That evening, the man blocked off his observation panel using bits of tissue paper and biscuit. He refused to talk to staff and wore a towel over his face. At 8.30pm, he began to repeatedly flush his toilet, turned on the taps and kicked his door. He used his cell bell to get staff attention and, when anyone came to see what he wanted, he swore at them. He was seen putting his hands under the running water and clapping. A den had been built in the centre of his cell which he sat in for most of the night.

153. The next morning an ACCT assessment took place. This routinely takes place within 24 hours of opening the form. The prisoner subject to the review may participate, but the man refused to take part so the registered mental health nurse and a senior officer went ahead without him. They noted that the psychiatrist had requested the man be monitored as there was a chance he might be psychotic. It was clearly entered on the form that the man was not displaying any risk to himself in terms of self-harm or suicide. Reference was made to his previous attempt at using a ligature in January 2005. However, as there were no current concerns or more recent attempts at harming himself, the observation levels were reduced from 30 minutes to hourly. It was also noted that a principal officer had questioned the appropriateness of using the ACCT document in assessing the man. As there was no other means of documenting continuous observations, the ACCT was kept open.
154. The man's behaviour worsened. He clapped incessantly, banged his door, drummed on surfaces, verbally abused staff, sucked his teeth in response to questions, spat at staff and sat in his den. On the afternoon of 14 January 2007, he lunged at staff twice and began another dirty protest later that evening, blocking his observation panel with excrement. This continued the following day and prevented a proper ACCT review from taking place. The mental health nurse tried to speak to the man at his cell door but he would not respond. He and another senior officer (also present for the review) spoke about alternative ways of monitoring the man's mental health as it was difficult to do so in the environment of the segregation unit. It was agreed that the ACCT should remain open, with hourly observations, until the psychiatrist came to the prison on 19 January.
155. A senior officer and governor also questioned the use of the ACCT. They thought that, as there were no concerns regarding self-harm or risk of suicide, opening the form was inappropriate. However, they were informed by a MHIRT nurse of the man's attempt to ligature in January 2005 and decided to err on the side of caution and keep the ACCT open until the psychologist's visit. Clarification would then be sought on the best course of action.
156. A segregation review board sat on 16 January. This time the personal officer statement was provided in advance. It said:

"The man's behaviour has deteriorated within the last reporting period. He sporadically kicks his cell door and constantly covers his observation panel which he has been repeatedly told about. He appears to be very much in his own world... His target to interact with staff and comply with regime has not been met. Over the weekend he commenced a dirty protest. His banging of the cell door continues to disrupt the unit."

A governor chaired the review. It was decided that the man's conditions and behavioural targets would remain the same. No reason was given to the man for his continued segregation on this occasion.

157. On 19 January, an ACCT review took place with the senior officer, a community psychiatric nurse, the registered mental health nurse and the segregation unit manager. They discussed the man's continued food refusal and felt this indicated a heightening of risk regarding his mental health. A food refusal monitoring process was enacted, but the man started eating again so it was stopped. His level of observation (hourly) remained unchanged.
158. Later that day, the man ended his dirty protest. He was allowed a shower and clean clothes, and moved cells. The man remained uncommunicative during his move, keeping his eyes shut throughout. The psychiatrist visited and discussed the levels of observation and monitoring with a principal officer. They remained hourly with one quality entry to be made four times a day (morning, noon, evening and night). (Manifestly, all entries on an ACCT should be meaningful. A quality entry should contain more information, e.g. detailing a conversation with the prisoner, making an observation on their mood and noting any changes.) It was also noted that the referral to Broadmoor was in progress, and that the forensic psychiatrist had been informed of the man's apparent deterioration. The psychiatrist added that the man "may well have a psychotic illness" and in his opinion he:
- "requires assessment in a high security hospital. Meanwhile the prison needs to as far as possible maintain his safety. Note previous history of homicide and attempted suicide. He has been formally observed hourly this week. I feel this should continue whether this is under ACCT or on an observation form."
159. During the night of 20 January 2007, the man banged the door and flushed the toilet in his room until 6.00am. He was becoming increasingly disruptive to the whole wing. The following morning, an ACCT review was held. The man refused to attend. The senior officer, segregation unit manager and MHIRT nurse decided to lower the assessed risk. The man had ended his dirty protest, had started eating again and showed no signs of self-harm or suicidal ideation. Despite this, his general behaviour had not improved and it was decided to continue using an observation book and to close the ACCT. The same level of observation was required – hourly, with four documented entries and one quality entry per day. In my view, this was an appropriate decision given the man's behaviour and demeanour.
160. Meanwhile, the man continued to bang his door and spit at staff. He also piled his furniture up against the door to obscure vision into the cell. When his cell was unlocked during the governor's management round on the afternoon of 21 January, the man charged at staff and initiated a violent struggle where he tried to grab an officer's keys. The man was restrained and put in one of the special cells to calm down. When staff later tried to move him back to his own cell, he refused to move and lay under the blanket. At 6.45pm, the MHIRT nurse spoke to the man. He refused to unblock his observation panel. The man told the nurse that he had a broken shoulder and wrist after being restrained. He did not want to be checked for injuries as he was trying to sleep and said he would see the nurse the following day. When this nurse asked what level of pain he was experiencing, the man refused to answer. A F213 form was started (this is

a form used to record injury in the event of use of force) and was completed by a doctor the next day.

161. During the governor's management round the next day, the man again moved his furniture up against the door and refused to move it until teatime. He covered his observation panel and spent the afternoon banging and clapping. Later that evening, he initiated another dirty protest, covering his observation panel and walls with excrement. He banged his door through the night, disturbing the wing and preventing prisoners from sleeping.
162. A prison officer that was on night duty on 23 January made an entry in the observation log at 6.33am that said he felt the hourly checks were unsettling the man and making the situation worse. The following night, the same officer asked the man if he would like his cell light turned off. The man said yes. He appeared to have a quieter night, although he kept his observation panel blocked using his furniture and mattress. His behaviour worsened during the day, returning to banging, clapping and verbally abusing staff. He refused his lunch, but did end his dirty protest, moving to another clean cell. The man did not interact with staff during the transfer and continued to bang the door throughout the night.
163. During the early hours of 25 January, the man's banging on the cell door led to other prisoners complaining. The man refused to stop when staff asked. He continued to be disruptive to the point where other prisoners became restless. Permission was sought from the duty governor to remove the water bottle the man was using to bang on the door. When staff entered the cell, the man refused to comply. He was restrained in the interests of staff safety, and moved to a special cell where he was observed every 15 minutes. The man was moved back to his cell without difficulty six hours later. His disruptive behaviour started again.
164. The imam spoke to the man during the afternoon on one of his daily visits. The man told the imam that he had not been given the following items:
  - toothbrush
  - toothpaste
  - soap
  - kit change
  - pens and paper

He wanted to complain formally about his bed and the lack of warm bedding. The man also stated that he had been denied contact with his solicitor. The imam relayed these points to the man's offender manager. (My investigator found no evidence to suggest that the man had been denied contact with his lawyer. However, he may have been refused some of the requested items – toothpaste or paper – on occasion to prevent him from blocking the observation panel.) During interview, officers told my investigator that the man would frequently decline application forms for making requests or complaints even though they were offered daily. There was no record of the man having submitted a complaint.

165. After their meeting, the imam spoke to the head of healthcare. He asked whether he could be present when the psychiatrist visited the man. The imam noted in the man's history sheet, "I still feel optimistic about restructuring his care." It is not altogether clear what progress had been made to date as the man was persistently disruptive and non-compliant with staff. His behaviour that night mirrored that of the previous night, only this time he was not relocated.
166. The man continued to be a source of disruption within the unit. He banged his door or the pipes day and night and built a barricade with his cell furniture to stop staff seeing him. He draped a blanket over the furniture to make a den and hid in it. He was warned to stop using his furniture in this way or it would be removed. At 1.00pm on 27 January, the man started another dirty protest, smearing excrement around his cell. This continued until 10.30am the following day. A governor asked the man if he wanted to end his protest and he agreed. The man was given a shower and moved to a clean cell. That night he continuously tapped the door and walls, and built a 'wall' to hide behind his furniture.
167. On 29 January, Long Lartin experienced a power failure and some prisoners were transferred to other prisons. The man was moved to HMP Woodhill for three days. He was placed on a six officer unlock with full protective clothing. An entry in the man's medical record on 31 January states that he was seen on the segregation unit by a member of Woodhill's healthcare team. The signature is illegible so it is not possible to identify who attended. The man said he was relapsing and wanted to restart his medication. The entry refers to his assessment for Broadmoor and requests for their mental health in-reach team to be contacted as soon as possible for a review. A doctor saw him the following day. The doctor noted that "no new issues were raised". The man was declared fit to transfer back to Long Lartin the following day.
168. When the man was told that he would be returning to Long Lartin he began a dirty protest. He had to be removed and placed in the escort van by use of force. Once on the van, the man calmed down. When he got back to Long Lartin the man was seen by the registered mental health nurse for a routine reception assessment. This nurse said that the man was "not fit for segregation but could not be managed in the healthcare centre inpatients due to his behaviour". (This comment is a useful insight into the man's presentation.) However, given no alternative suitable accommodation and being ineligible for secure hospital detention, the segregation unit was the only place he could be held. The man refused to speak to the registered mental health nurse, placed a towel over his head and danced around his cell.
169. By 2 February, the man had started another dirty protest. He threw urine through the door at staff, continually banged on his door and disturbed the other prisoners. The man blocked off his observation panel using toothpaste. He told the imam that he wanted to transfer to HMP Frankland. It is not recorded why he wanted to transfer to this particular prison, or if anyone asked him at a later date why he wanted to move out of Long Lartin.

170. The offender manager and the imam both saw the man on 3 February. The man spoke about writing to his family and arranging a visit. He said that he wanted to transfer prisons and see his family as they encouraged him to behave better. The man told the offender manager and the imam that he had no bed or mattress cover, only one set of clothes and no kit change since his return to Long Lartin. He wanted to send a visiting order to his uncle, but had no pens to fill it in. The man had not mentioned his lack of pen to the offender manager. My investigator found no evidence that his complaint was dealt with or that he was provided with writing materials. Again, there is no record of why he wanted to move prisons.
171. On 4 February, a governor telephoned healthcare to inform them that the man had been restrained again. He had been banging continuously and refused to stop. Other prisoners in the unit had complained about the noise, asking staff if they could “shut him up”. At 5.30pm, the same governor authorised staff to remove the cutlery that the man was using to drum on the door, as well as his furniture. Staff entered his cell and a struggle followed. The man charged at staff. He was restrained and relocated with the MHIRT nurse present. (All planned use of force requires a member of healthcare to be present during the manoeuvre.)
172. This governor asked about the man’s referral to Broadmoor, emphasising that he was becoming an increased risk to himself and staff. The MHIRT nurse made a note on the man’s file for the registered mental health nurse or a member of MHIRT to update this governor. The registered mental health nurse spoke to Broadmoor the next day. He was told that, due to concerns over his feigned symptoms, the man had been declined admission by the initial admission panel and then at the external appeal panel. The registered mental health nurse contacted the Mental Health Unit at the Home Office to see what next steps could be taken. The Mental Health Unit requested further information from the prison on the man’s sentence, the court result sheet, breakdown of his offence and any probation pre-sentence reports. The registered mental health nurse updated the governor and psychiatrist of the situation, and requested that the discipline office and probation officer fax the relevant documents to the Home Office.
173. A segregation board review was held the same day, chaired by a governor. It was noted that, “the man’s behaviour is very bizarre and does not change for the best, only deteriorating on a daily basis.” The unlock protocol was increased to an SO and six officers in full PPE. New behaviour targets were set:
- to stop behaving bizarrely
  - to have consideration for other prisoners and not make noise at night
  - engage properly with healthcare staff.
174. A prison nurse supplied supporting information in advance of the board review. He said that given the man’s level of threat to staff, himself and his violent outbursts, the segregation unit was the best environment for ensuring safe

control and ongoing close monitoring. In addition, “there is no benefit to be gained from intensive healthcare intervention”. The governor told the man that he was to remain in the segregation unit pending a close supervision centre (CSC) referral and assessment. It was decided that referral needed to be the next step, as the man was showing no signs of progression.

175. The CSC system specialises in dealing with disruptive and violent prisoners who cannot be managed within the normal prison system and are unable to progress out of segregation. Prisoners are referred to the CSC to help them progress back to normal location after intensive work to address their behaviour. The CSC is co-ordinated centrally at HMP Woodhill and HMP Whitemoor. Prisoners are referred to a committee that meets on a monthly basis. A governor and principal officer from Long Lartin sit on the committee. If accepted into the system, prisoners are intensely supervised by staff. Once prisoners have progressed through the system they are returned to satellite CSC areas, of which Long Lartin is one. This process can be very lengthy. Referral to the CSC is usually deemed to be a last resort.
176. For the next few days, the man’s behaviour carried on in the same vein. Other prisoners on the unit made complaints to staff about him. A segregation prison officer noted in the segregation unit observation book that the man was overheard talking at length to a prisoner through the cell windows. The conversation was said to be “normal”. After this short interlude, he resumed causing unrest on the wing by banging, shouting abuse and spitting at staff.
177. On 7 February, the offender manager, the imam and the IMB member talked to the man at his cell door. The man interacted in a limited capacity but covered his head. The offender manager reminded him of his positive conversation with the home offender manager a month earlier. The man responded by removing the towel and allowed his visitors to see his face. He spoke about his time at school where he had played drums in a band. The offender manager felt this explained his “rhythmic abilities” (the constant tapping and banging). She asked him if he would start interacting with staff on the wing and encouraged him to write to his aunt and uncle whom she knew had been making enquiries about him. The man “appeared surprised that they wished to talk to him”.
178. The offender manager, imam and IMB member saw the man again on 9 February. During this meeting he again complained about his inadequate bedding and said that he only had one set of clothes. He had not been issued with a change of kit since returning from Woodhill. Aside from noting his complaints in the history book, it was not clear to my investigator how or if the man’s complaint was officially addressed. Later that day the man agreed to take an application form to submit some phone numbers to the PIN system to enable him to contact his uncle. (The PIN system registers the phone numbers of nominated and approved contacts for each prisoner. All prisoners are allowed ten personal numbers in addition to official contacts such as solicitors.)
179. Shortly after this meeting, the man resumed his disruptive behaviour, very limited cooperation and communication. He declined to see the registered

mental health nurse or any of the other CPNs on their daily rounds and blocked off his observation panel.

180. A mental health review with the psychiatrist took place later in the afternoon. The man refused to be seen, but the psychiatrist noted in the medical record that he had been observed talking to another prisoner without displaying bizarre behaviour for 30 minutes. The psychiatrist liaised with the forensic psychiatrist from Broadmoor about the man's referral. The forensic psychiatrist again declined to accept the man as he did not believe him to have a psychotic mental illness. He found the primary diagnosis to be psychopathy or anti-social personality disorder, which he said did not warrant hospital admission. The forensic psychiatrist said that Broadmoor would review him again in two to three months. The psychiatrist remained concerned regarding the man's bizarre behaviour and he continued the ongoing review.
181. On 14 February, the man began another lengthy dirty protest, smearing excrement over his observation panel and banging the door. Both officers and healthcare staff found the man's behaviour to be notably deteriorating. Options for finding the best solution for managing the man were limited. He was still awaiting assessment for the CSC. Behavioural targets set at the segregation review board remained the same – to comply with the regime and medical assessments, and show consideration to other prisoners on the unit. The man consistently failed to meet these.
182. The offender manager and a member of the IMB attempted to talk to the man 20 February. Communication during this visit was impossible as the prisoner in the cell next door was "shouting, swearing and complaining on his behalf" with regard to questions put to the man. The offender manager said that without this influence they might have had a more successful conversation.
183. Over the next two weeks the man was frequently placed in a special cell for disrupting the wing. This was felt to be the only option available to staff to prevent him causing unrest, particularly at night. Restraint was often used as the man would charge at staff and try to attack them when his cell door was unlocked. Other prisoners in the wing were making desperate requests to staff to get the man to stop the banging and drumming. On 1 March, several prisoners threatened to "smash up" their cells or self-harm if he was not stopped or moved. They were advised by staff to remain calm. The man was placed in one of the special cells for the night.
184. Referral documents were sent to the CSC system committee at the Directorate of High Security Prisons in Prison Service Headquarters during the first week of March. The overarching reason given for referral was violence towards staff and prisoners. The following staff were asked to provide supporting submissions with the referral: the wing manager, the security officer, the mental health team leader and trainee forensic psychologist. The psychiatrist was not asked to provide a statement.
185. The wing manager cited poor interaction with staff, non-compliance (dirty protests, blocking his observation panel, continuous banging) and assaults on

staff as reasoning for referral. In his opinion, a referral to the Dangerous and Severe Personality Disorder Unit (DSPD) would not be appropriate at this stage as it would require a level of compliance and engagement that the man could not demonstrate. The security officer added that no prisoners should associate with the man as he was violent and demonstrated a “profound lack of empathy or remorse for his actions”.

186. The mental health team leader gave an overview of the man’s mental health history. She explained that there had been conflicting diagnoses whether the man had displayed psychotic symptoms, or suffered from a personality or behavioural disorder. It was explained that Broadmoor had declined to admit the man as he was not unwell enough to warrant a hospital admission and could be feigning illness.
187. The trainee psychologist provided a full and in-depth report on the man’s mental health history, citing his record of violence both in and out of custody. He recommended that the man would benefit from being managed within a specialist unit, such as a CSC unit as it might help to stabilise his behaviour. The trainee psychologist also recommended that the man be subject to further assessments to see if he would be suitable for a Dangerous and Severe Personality Disorder (DSPD) unit. He firmly stated that in the meantime the man remained a high risk to both staff and prisoners at Long Lartin and that serious consideration should be given to a placement in a CSC unit.
188. Over the next week the man calmed down. Aside from smashing the radio he had borrowed from the chaplaincy, there were no documented periods of disruption. He was quiet during the night and compliant with staff. On 13 March, the segregation review board recorded that the man had made a “complete turnaround – no knocking, no violence – continue with positive progression”. There had been no recent instances of dirty protests or need for restraint. The man had taken possession of some items of property, sent a letter and a visiting order. He was encouraged to continue with this positive progression. It was noted during the following week’s review board that his improved behaviour had continued. The man had started taking exercise and better care of his personal appearance.
189. Unfortunately, this changed on 26 March. The man flooded his cell. Staff could not identify an apparent trigger for this change. His water supply was temporarily switched off. The following day he was given cleaning equipment and told to tidy his cell. Two days later, the man started a dirty protest and spent the day banging on the walls, door and window with his cup throughout the night. He stopped communicating with staff and laughed when they attempted to converse with him. The registered mental health nurse saw the man and reported that, despite being on a dirty protest, he seemed to be in good spirits. The imam visited the man on 30 March and appealed to him to cease his protest as it was not in keeping with his faith.

## Sunday 1 April 2007

190. At approximately 12.00pm, the man pressed his cell bell. A senior officer responded and went to his cell. The man told her he wanted to end his dirty protest. At 4.00pm, the senior officer and four officers put on their PPE, took a shield and opened his door. The reason for the delay was that sufficient staff needed to be available to assist with the unlock and supervise the move. One of the segregation prison officers instructed the man to place his hands on his head and walk out backwards towards the shield. A bucket of water and a cleaning kit were put in the cell. The man made an effort to clean some of the mess. Twenty minutes later he was moved from his cell to the showers and given clean clothes. He kept his hands on his head, his eyes shut and smiled as staff directed him. Staff told my investigator that the man would often close his eyes on moving around and preferred to be guided by staff. It seemed to be an alternative to covering his usual practice of covering his head so his face could not be seen.
191. The man complied with staff instructions, moved into cell 113 at 5.00pm, and was given clean clothing. By this time dinner had been served. The man's food had been placed in his cell. The prison officer from segregation noticed that there was no table or chair in his cell, so an officer went to get him some furniture from another unoccupied cell. As it was the weekend, the lock up that day was early.
192. Once prisoners had been locked up after dinner, the next mandatory check on cells was during the early evening. Day staff perform a check at approximately 7.30pm and then another check is made by oncoming night staff at around 8.30pm. The only exception to this rule is for category A prisoners or those on an open ACCT. Category A prisoners are checked every hour and those on an ACCT should be checked in accordance with the observation requirements. The man was a category B prisoner and not on an open ACCT and so would not be checked until the evening roll check unless he called for staff attention. His ACCT had been replaced by an ongoing observation book on 20 January. There was nothing untoward reported regarding any of the prisoners during the 7.30pm check.
193. At approximately 8.20pm, another prison officer came onto the wing for night duty. He received a handover from the two segregation prison officers in the segregation office, which is on the upper landing. No concerns were noted about any of the prisoners. The night officer went downstairs and started a roll check. The roll check involves looking through the observation panel in each cell door to check that all prisoners are in their cells and that there are no problems.
194. When the night officer arrived at cell 113 at 8.30pm, he looked through the panel and saw the man hanging by a ligature suspended from the right-hand side of the window. The night officer immediately raised a "code blue" alarm via his radio and requested "all staff to seg unit". (Code blue means that there is an urgent medical emergency with a likelihood of breathing difficulties and possibly a hanging. This means that all staff attending should come prepared,

particularly medical staff, bringing with them the emergency response kit.) The night officer also requested permission to enter the cell on his own. Staff are required to wait for instruction to enter a cell, even in an emergency situation. The man was still on a multiple officer unlock and there have been instances where prisoners feign injury in order to attack staff. Despite this concern, permission was immediately given to enter the cell.

195. At the same time as the radio message was sent, an Operational Support Grade (OSG), who was in the control room, telephoned the centre office. A senior officer answered and the OSG told her to go to the segregation unit immediately. The senior officer from the centre office instructed staff to follow her to the unit. The staff on duty at that time were a mix of day staff and night staff as it was handover time. The OSG asked a principal officer to override the electronic gates between wings to allow staff to move quickly to the incident. This was done.
196. At the same time as permission was given to enter the cell, a prison officer from Perrie wing – the wing next door arrived. It took him “a matter of seconds” to arrive. On seeing this prison officer, the segregation officer shouted “officer, quick help!” The prison officer from Perrie wing ran to the cell and they entered the cell together at 8.33pm. The man had knotted a bedsheet and forced the knot through the gap in the hinged side of the window. He was upright and there were pieces of broken cardboard furniture underneath his feet. The officer from Perrie wing supported the man’s body whilst the segregation officer tried to cut the ligature using his anti-ligature knife. All officers carry this knife on their belt. The ligature was too thick to cut as a whole sheet had been used and twisted tightly. The officer from Perrie wing tried to push the window open as far as it would go to slacken the bedsheet. The segregation officer was unable to open the window fully, but did open it enough to unravel the ligature slightly and allow them to lift the man. Both officers took the man’s weight to keep the ligature loose until more staff arrived to assist. The segregation officer noted that the man had been incontinent of urine.
197. At 8.35pm, the control room telephoned emergency services and requested an ambulance. The senior officer from the centre office, the segregation officer, and four other officers arrived on the unit. They could not immediately see which cell to go to so shouted, “Where are you?” the segregation officer on night duty directed them to cell 113. On arrival, another segregation officer helped the two segregation officers to support the man’s legs whilst the senior officer from the centre office used her anti-ligature knife to cut through the ligature where it was fixed at the window. They made use of the broken cardboard on the floor and placed the man on it. The night duty segregation officer removed the bedsheet from his neck. The senior officer noted that the man did not appear to be breathing and his eyes had rolled back. She asked everyone apart from the two segregation officers to move out of the cell.
198. The prison nurse arrived with an emergency response bag and oxygen. He checked for signs of life. This nurse could find no signs of pulse or cardiac activity. The man’s eyes were half open and his pupils fixed and dilated. Mild cyanosis (which means the person has turned blue due to lack of oxygen) was

evident around his lips and finger tips. Along with a segregation prison officer, the prison nurse began administering cardio pulmonary resuscitation (CPR). He gave an initial precordial thump and then took charge of the man's airway, whilst the segregation prison officer managed chest compressions. (A precordial thump is a single carefully aimed blow with the fist to the centre of the sternum. It is a medical procedure used when a defibrillator is not immediately available. The performance of a precordial thump is outside the scope of first aid and requires, at minimum, training in advanced cardiac life support. The prison nurse is qualified to perform this course of action.)

199. The segregation prison officer and the prison nurse told my investigator that they remember the man felt warm to touch on his back area at this time. The prison nurse was unable to intubate the man as his jaw was immovably locked, although no rigor mortis had set in. Oxygen was continuously administered using a face mask, with his head tilted back to improve his airway in the absence of intubation.
200. The senior officer from the centre office requested a defibrillator at 8.37pm and checked with the control room that an ambulance was on its way. An OSG was asked to put a radio message out asking for the defibrillator to be brought to the cell. Simultaneously, A officer telephoned the healthcare unit to let them know that the defibrillator was required immediately. He was told that a second prison nurse, who had just come on night duty, was on his way with it. The senior officer told the two segregation prison officers to leave the cell as they were visibly distressed.
201. At 8.45pm, the senior officer from the control room placed a call out over the radio to say that the man had stopped breathing and resuscitation had commenced. A prison officer in the control room telephoned the emergency services and updated ambulance control on the man's state. The second prison nurse and another officer arrived at the cell with the defibrillator. The second prison nurse attached the defibrillator to the man. The machine gave a reading that said not to defibrillate (no shock was required) and to continue with CPR. The defibrillator was checked at intervals and it repeatedly gave the same reading. There continued to be no signs of life. The officer took over chest compressions from the segregation prison officer. The ambulance arrived at 8.45pm, but it took ten minutes to get through security so it did not arrive at the unit until 8.55pm. The paramedics were unable to find any signs of life and pronounced the man dead at 9.00pm.

### **Events after the man's death**

202. The senior officer from the control room requested that the control room notify the police and ask them to come to the prison. The duty governor arrived at the prison at 9.10pm and went straight to the control room. The deputy governor was already at the prison and in the segregation unit. She made sure that staff were all right and asked whether she could do anything for them. The night duty segregation officer provided her with details of what had happened. Provision was made to support staff and the care team was contacted.

203. The death in contingency plan was put into action, with all relevant paperwork collated. A hot debrief with all staff involved in the incident was held in the segregation unit office. The police were present and a discussion was held regarding contacting the man's next of kin. The prison's family liaison officer arranged with the detective sergeant to liaise with Wandsworth Police to notify them of the death prior to visiting the family home. The imam and another family liaison officer assisted this governor in informing the man's family.
204. The man's uncle told my family liaison officer that the prison's other family liaison officer was very helpful and supportive, particularly to the man's aunt. This prison family liaison officer kept the family involved and informed throughout. The man's relatives were invited to visit the prison.
205. The prison paid for the repatriation of the man's body to Uganda for burial. This was right and proper (and beyond the expectations of covering the cost of funeral expenses specified in Prison Service Order 2710 'Follow up to deaths in custody'). Representatives from the prison attended a service held in the UK.

## ISSUES

### Transfer between prisons

206. The man was originally taken into custody at HMP and YOI Chelmsford. At the time of his offence he was 19 years old and would have been automatically placed in a YOI. After a period of eight months he was transferred to an adult male prison, Belmarsh. It has not been possible to ascertain why the man was moved to an adult male prison as the transfer papers are no longer with his prison record. Without seeing the documents, my investigator was unable to comment on whether the transfer was appropriate.

207. The man transferred from Chelmsford's healthcare unit to that in Belmarsh. It appears that staff at Belmarsh were briefed about his arrival and on his mental health history. The man remained at the prison for less than two months when he went to the John Howard Centre (JHC) for assessment. Unfortunately, the decision to return him from JHC to Belmarsh was not shared with the mental health team. They were given no prior warning despite the fact that JHC would have known the man was to return due to his unmanageable behaviour. A consultant psychiatrist at Belmarsh, explained to my investigator:

“... at the time prison hospitals had the ability just to send people back and it was not very satisfactory because when he came back on 22 December he just arrived. There was no warning, there was no information about him, what the outcome of the assessment was, what their findings were, the reason why he came back etc etc, he just arrived.”

208. The consultant psychiatrist went on to explain that the system had since changed (for unrelated reasons). Secure mental health units now have to check whether receiving prisons have been fully briefed before transfer, and meetings are held to discuss patients. The lack of consultation and a discharge plan at the time was unhelpful, particularly as this man had recently been taken off his medication and had been very violent. It was not clear whether his assessment had been completed or if he had simply been returned as he could not be managed safely.

209. The man remained at Belmarsh until 20 October 2006. His transfer at this time was between segregation units. A governor made a request to the high security estate for a transfer between segregation units. Requests for transfer between units should only occur when there is no other option available. Ideally, a prisoner should progress out of a segregation unit. Reasons for transfer can be:

- The prisoner's attitude and behaviour have become such that staff and others have lost confidence in the prisoner's ability to change in the current environment.
- The prisoner has been recategorised and upgraded and therefore needs to be transferred to a more secure establishment.

- The prisoner has refused to leave the segregation unit at the end of their period of removal from association. The prison policy may be to transfer out prisoners who take this course of action.
- The prisoner's status has changed (e.g. they have been classified as a vulnerable prisoner) and the prison does not have any suitable accommodation.
- The prisoner is being transferred under the Management Strategy for Disruptive Prisoners policy (PSO 1810 Maintaining order in prisons).
- The prisoner is being transferred to a DSPD (Dangerous & Severe Personality Disorder) unit or a CSC (Close Supervision Centre).
- The prisoner is believed to represent such a danger to another prisoner or a member of staff that they cannot be reasonably returned to the main accommodation of the prison for the foreseeable future.
- As a progressive move for the prisoner with the incentive for a fresh start.
- If it is recommended by an ACCT case review.

In this instance, the request was made due to the man's difficult behaviour and continued threat to others preventing him from returning to the main accommodation of the prison. The governor at Long Lartin agreed to accept the man.

210. The governor provided a written statement about managing the man at Long Lartin. He said the man had been transferred to Long Lartin as a first prison allocation following conviction. Long Lartin was identified as an appropriate prison as it is well equipped to deal with violent and disruptive prisoners. The transfer paperwork indicates that the request for transfer was made to allow Belmarsh staff respite and to provide a different environment for the man in the hope that it would encourage improved behaviour.
211. It was not ideal to transfer the man straight to another segregation unit for 'change of environment' purposes. However, given his heightened risk to others he would not have been suitable for normal location. Additionally, staying at Belmarsh seemed to be exacerbating rather than improving the situation. I judge that under these circumstances the Governor at Belmarsh acted appropriately in requesting a transfer. The requisite paperwork was completed prior to transfer and Long Lartin staff were briefed of the situation.
212. The healthcare team were not briefed on the man's presentation or provided with his mental health history prior to his arrival. His medical record did not travel with him at this time, and so his initial health screens relied on information that the man shared. During his initial health screen, the man told

the registered mental health nurse that he had not been receiving medication for six months, was settled at Belmarsh and had been receiving occupational therapy. This was not true. The man did, however, say that he had been transferred because he had assaulted staff.

**The Governor at Long Lartin should consider how best to ensure that all staff are fully briefed before receiving prisoners with a history of mental illness.**

213. In addition, the man did not appear to have been informed about his transfer. According to Prison Service Order 1700 (Segregation), all prisoners, with the exception of those on escape list or category A, are normally told if they are being considered for a transfer to another establishment and which prison they will be going to. It is not documented anywhere whether the man was told he would be transferring.

**The Governor at Belmarsh should remind staff of the Prison Service Order 1700 (Segregation) requirement that all prisoners, with the exception of category A and E list prisoners, are informed if they are to be transferred to another establishment and told where they will go.**

#### **The man's period in segregation**

214. The man spent seven and half months until his death in segregation. Notwithstanding his high-risk violent and unpredictable behaviour, this is a long time for anyone (let alone a very young man) to spend in a segregation unit. It is recognised that segregation impacts on the health of an individual as well as increasing the risk of suicide. Prisoners who are already at risk (by virtue of mental illness, threatening suicide or self-harm or detoxification) should only be placed in segregation when their disturbed or violent behaviour towards others makes location elsewhere impossible. Unfortunately, in this man's case I believe there was no other option at either Belmarsh or Long Lartin as he continually posed a threat to others. The man's periods of relative calm during those seven months never lasted long enough for him progress to normal location or for transfer to the healthcare unit.
215. The governor explained in his statement that the strategy for working with the man at Long Lartin had two initial aims:
- to satisfy themselves that the man could be safely held within segregation, taking account of his mental health and behavioural issues
  - work with the man to enable him to move to a normal location and start progressing through his life sentence.
216. Unfortunately, the man was unable to progress to the second stage of the strategy and spent a considerable amount of time in the segregation unit. The next step was to resubmit a referral for transfer to a secure hospital.

Broadmoor again assessed him as being unsuitable for transfer, but agreed to keep the decision under continuous review.

217. My investigator spoke to the segregation unit manager at Long Lartin. They discussed the length of time prisoners can remain in segregation. This manager told my investigator that ideally a prisoner should not spend a long period in the unit. If a prisoner is detained in the unit for Good Order or Discipline (GOOD) purposes, the aim is to work to improve their behaviour and move them back to the main prison as soon as possible. Placement on the unit is regularly reviewed, with input from both discipline and healthcare staff. If the prisoner is medically unfit to be segregated, a move to healthcare can be considered. However, if the risk is deemed too high then the prisoner would either continue to be managed in the unit or referred to a secure hospital.
218. The segregation unit manager at Long Lartin told my investigator that three months was the maximum time a prisoner should really be in the segregation unit. If their behaviour had not improved in that time, this could be an indication that something was wrong and that a referral to the close supervision centre (CSC) system might be necessary. As the man was clearly not making any progress after five months on the unit, consideration was in fact given to transferring him to a CSC unit. The CSC system specialises in dealing with disruptive and violent prisoners. It is also skilled at progressing individuals back to normal location after intensive work to address their behaviour. The segregation unit manager could not offer any reason as to why the referral was not triggered at the third month. There had been earlier discussions about referral, but nothing was formally done until 2 March 2007. A final decision had not been made by the point at which the man took his life. The governor said:
- “If this submission had not been successful, we would have finally been looking to transfer the man to another prison and we had identified the possible need to undertake work at the Dangerous and Severe Personality Disorder (DSPD) Unit at HMP Frankland.”
219. My investigator asked the segregation unit manager whether the man could have been treated as a CSC prisoner at Long Lartin given that they had the facilities (high control cells and trained staff) to manage CSC prisoners. The segregation unit manager explained that the high control cells are for prisoners who fit into the CSC category who come from a local prison, or prisoners who are already in the system and have been transferred to give staff some respite. Thus Long Lartin provides temporary CSC care, rather than full-time. Occasionally, prisoners are transferred to other CSC locations to see if their behaviour improves in a different environment. This is for much the same reason as the man was moved from Belmarsh to Long Lartin in October 2006.
220. When there is a CSC prisoner on the wing two officers are detailed to manage and support him. This is because a CSC prisoner demands more staff attention. For continuity and to foster better engagement, the same staff manage the prisoner. Staff time with such prisoners is more concentrated than with other prisoners on the segregation unit. However, the segregation unit manager explained that, in his opinion, there was little difference between the

frequency of attention that the man received from staff and that which any CSC prisoner on the unit would receive. Due to his recurrent disruptive behaviour and ongoing mental health assessments, the man received frequent staff contact. For my part, I am reluctant to draw such a close comparison. The frequency of attention that the man received was reactive and did not equate to the type of staff contact that a CSC prisoner would receive. Had this man been a quieter prisoner, staff contact would have been the same as with any other prisoner on the segregation unit.

221. Despite the additional attention he received, the man largely refused to engage with officers. Apparently all of these strategies had been explained to the man, but as the governor said, "it was fair to say that he did not positively engage in a way that would have allowed earlier progress from Long Lartin." Both healthcare staff and officers were unable to determine whether his behaviour was attention-seeking or a symptom of a mental health illness. His symptoms were erratic, exaggerated and not consistent with any one treatable diagnosis.
222. It is difficult to see what else in practice staff at either Belmarsh or Long Lartin could have done, other than to have referred the man to the CSC system at the three-month mark. Secure hospitals will not admit prisoners with conditions deemed untreatable, and this leaves the prison system struggling to provide an adequate duty of care to unmanageable prisoners. Discipline staff are not trained psychiatric nurses, and the nursing staff available to support officers is limited. Prisoners such as the man need controlled and continuous care to encourage engagement and reintegration into the main prison system. This cannot be done within the segregation unit, or in normal location or healthcare when there is a high risk of violence. The use of the segregation unit for the man's placement was probably the least worst option. Segregation unit staff suggest that permanently basing a registered mental health nurse on the unit would improve the delivery of care to prisoners like the man. The Worcestershire Primary Care Trust commissioners need to consider this and, with the prison, take a view about the numbers of prisoners with similar problems and the facilities available for them.

**Worcestershire Primary Care Trust and the Governor at Long Lartin should consider allocating the equivalent of a full-time registered mental health nurse to the segregation unit.**

223. It is difficult to determine whether the man's behaviour was a means of distracting himself from his symptoms or whether he was simply being disruptive. Either way, as I have said in previous investigations and in my 2006 Annual Report, "giving vulnerable prisoners something to occupy their time is likely to be a crucial part of their welfare in segregation." HM Chief Inspector of Prisons echoes this in her 2007 thematic review, the mental health of prisoners. HM Chief Inspector of Prisons recommends:

"Staff with expertise in mental health should work in conjunction with segregation unit staff to ensure that prisoners held in segregation are supported and provided with appropriate distracting activities. It is clear that serious thought needs to be given across the prison estate to

identifying practical measures to providing a regime that relieves the boredom and isolation. It is crucial to promoting and safeguarding mental health.”

### **Action plan for the man’s progression from the segregation unit**

224. A governor, the imam, offender manager, and the IMB forged a relatively positive relationship with the man in the segregation unit. They were able to talk with him at his cell door. On one occasion, they took him up to the adjudication room and tried to create an action plan with the intention of returning him onto normal location. The action plan comprised small milestones that were easily achievable, or seemingly so. The governor told my investigator that he was not sure that the man ever fully embraced the plan. He sporadically interacted and any positive engagement over the plan was short-lived.
225. Both the governor and the imam tried to explain to the man that, if he did not take steps to get off the segregation unit, he was facing a referral to the CSC. The imam used to say, “look this is where you’re going and you don’t want to go to CSC, it’s a dark place.” The imam explained that once the man was in the CSC system it would take a huge effort to get out. The action plan was an attempt on their part to intervene before the man reached the CSC. However, as a long-term prisoner in the segregation unit and with a history of assaulting staff, that was where the man was heading.
226. Whilst I commend the continued input of this governor, the imam and indeed all the discipline staff who encouraged the man to improve his behaviour, I again wonder whether more could have been done at an earlier stage.

### **Dirty Protest**

227. Whilst at Belmarsh and Long Lartin, the man frequently held dirty protests. Healthcare staff and officers at both prisons appropriately dealt with them, but my investigator was not provided with the documentation used to log the protests for each occasion. Nevertheless, there are entries in the man’s history sheet, medical record, segregation log and references made in IMB paperwork when the protests were taking place. During the protests, the man was seen daily by a member of healthcare and asked if he wanted to bring the protest to an end. On the occasions when he did end his protest, the man was promptly offered a shower, clean kit and moved cells.
228. There is little that can now be known about why the man held dirty protests. As he mostly refused to engage with staff it was difficult at the time to ascertain a reason. On one occasion he said that he did it because it annoyed staff. The imam was the only person able to get the man to speak. He worked hard to persuade the man to stop his dirty protests, explaining that such behaviour was not consonant with his religion. He told the man that whilst on a dirty protest he would not be given a prayer mat or the Qur’an. The man did not appear to respond to this advice and continued with his protests until he decided to end them.

## Unlock protocol and use of force

229. During the man's time in the segregation units at Belmarsh and Long Lartin, he was subject to a multiple person unlock protocol and use of force. His risk to others was continually high as he had frequent violent outbursts and was non-compliant.
230. To be unlocked from his cell, the man was required to stand against the back wall of his cell and move out slowly with his hands on his head. Staff had to wear full personal protective equipment, sometimes with a shield to move the man around the unit. On occasion, restraints would be used.
231. Controlled force can be used against prisoners for the following reasons:
- to prevent injury to self
  - preventing self-harm
  - preventing injury to a third party
  - preventing damage to property
  - preventing an escape or abscond.
231. Sometimes other events might result in use of force, such as a prisoner repeatedly refusing to unblock an observation panel or refusing to leave a cell or move to another location. Use of force should be authorised by a supervising officer, and only deployed when verbal reasoning does not de-escalate the situation.
232. When force is used, a 'Use of Force' form (F2326) must be completed to account for action taken. Incident details must be provided – the event that triggered the use of force, why it was necessary, statements given by staff involved and a record of what kind of force was used (controlled restraint, ratchet handcuffs, baton). A member of healthcare staff must see the prisoner after the event and assess them for injury. A F213 form ('Report of injury to inmate') has to be completed, whether an injury was sustained or not. If it is a planned control and restraint intervention, a member of healthcare has to be present during the incident itself. If it is spontaneous use of force, healthcare needs to see the prisoner at the earliest time within a 24-hour period. The move should also be recorded on CCTV, if available.
233. If the prisoner is moved to special accommodation (temporary confinement), the duty governor must give authority for this to happen. It should not take place without approval. The duty governor must give justification for the decision. Once a prisoner has been relocated to a special cell they must be seen by a healthcare professional as soon as is practicable. The professional must state if there are any clinical reasons for the prisoner not being confined. Staff must physically check a prisoner placed in a special cell five times an hour. At Long Lartin, a CCTV camera is fitted in both special cells to allow for constant observation. These cameras are only switched on when a prisoner is placed in the cell. There is an officer in the segregation unit who has sight of this camera and the other CCTV cameras on the unit.

234. There is no maximum length of time for remaining in the cell. The prisoner remains confined until they have calmed down, stopped issuing threats and being violent. If the prisoner is in the cell overnight they should be provided with bedding and clothing.
235. The use of force form has to be countersigned by an orderly officer and the duty governor. The Independent Monitoring Board should also be notified as soon as possible. If the prisoner remains in the special accommodation for a long time, the duty governor should visit twice in a 24-hour period, with a review held at the end of the period. Likewise, a doctor or registered nurse should visit at least twice in a 24-hour period. All visit comments must be logged.
236. At Long Lartin, the man was often placed in special accommodation by use of force. This was usually because he had attacked staff, repeatedly refused to comply with staff requests to unblock his observation panel or stop banging his door and other fixtures or fittings, for physical threats towards staff, or for refusing to move out of his cell. Staff never had to use the baton, but ratchet cuffs were used on occasion. The special cells should not be used for punishment purposes, but for defusing confrontational situations. All prisoners are strip searched before being placed in a special cell.
237. The use of force and placement in a special cell are reactive measures rather than actions to address behaviour in the long term. Placing the man in a special cell only had a temporary calming effect. Once back in his own cell he would revert to being disruptive. I understand the reasoning for resorting to these measures, particularly when the man was being violent. Staff told my investigator that he was difficult to reason with and often would not respond to requests or verbal warnings. My investigator has found no evidence to suggest that the man was placed in a special cell or that force was used inappropriately. I am not comfortable with the fact that on occasion the man was placed in a special cell due to the level of noise and disruption caused by his banging and drumming during the night. However, for the sake of keeping peace on the unit, especially when staff said other prisoners were threatening to respond with similar behaviour or self-harm, I am unsure what alternative action could have been taken.
238. For the majority of the instances where use of force was used, the paperwork is complete and the IMB were informed. However, there are a number of forms that were not signed off within a reasonable timeframe by the duty governor. Indeed, on a number of occasions the forms were not signed until a few weeks after the incident. My investigator asked the segregation unit manager, why the forms were signed so late. This manager said that the forms should be signed as soon as is practicable. He said that the delay was not typical and could not explain it.

**The Governor at Long Lartin should remind staff and Duty Governors involved in instances of use of force to check and sign paperwork at the earliest opportunity.**

## The question of bullying

239. My investigators received six letters from prisoners on the segregation unit. Several also responded to the notice of my investigation posted in the unit. My investigators spoke to a number of the prisoners who made accusations about how staff treated the man prior to his death. Despite following up on the allegations during interviews with staff, my investigators found no evidence to corroborate the prisoners' claims.
240. One of the prisoners in the wing submitted a formal complaint claiming that at 5.00am on 19, 20 and 21 February 2007, an officer banged the flap covering the observation panel to deliberately disturb the man when he was being quiet. The prisoner said that the officer was bullying the man. This complaint was formally investigated by the Governor at the time. No evidence was found to substantiate the allegation and the officer was cleared of any wrongdoing. The officer in question said that he was performing a standard early morning roll check. As the man had covered his observation panel the officer needed to get a response from him to see that he was okay. The officer explained to my investigators that normally he would talk to prisoner to get a response and get them to remove the blockage, but the man would not reply. My investigators asked for access to CCTV footage for the days concerned, but the tape had been re-used and the footage was no longer available.
241. My investigator was provided with a security intelligence report (SIR) dated 18 June 2007 which recorded that another prisoner on the segregation unit told an officer that two prisoners (who had since moved to HMP Frankland) were organising a campaign against staff. The plan being to "implicat[e] staff in wrongdoing prior to the man's death". The prisoner who reported the information would not make a formal statement to the prison but said he would speak to my investigators. The prisoner who had moved to HMP Whitemoor was interviewed. He had not been at Long Lartin at the time of the man's death, but he had heard prisoners on the wing inciting others to blame staff.
242. Another prisoner gave a similar account. He said that it was other prisoners on the wing who were verbally abusive to the man. They would shout names such as "nonce" and "rapist", in addition to threatening to "kick the shit out of him" on the exercise yard. On occasion they would encourage him to kill himself so that he would be quiet. This other prisoner believed that the shouting was a reaction to the man's constant banging and disruptive behaviour. However, the more the prisoners shouted at him the more the man's behaviour escalated. He said that it was a vicious circle. This other prisoner told my investigators that there was no foundation to the claims that staff were bullying the man. He said that he had overheard prisoners colluding to blame staff for his death. In his opinion, the staff handled the man to the best of their ability and tried to talk to him and help.
243. During interview, the unit manager substantiated the other prisoner's claim that some prisoners were hostile towards the man because of his behaviour. He said that some prisoners would tell staff, "If you don't get rid of him I'll smash up." The segregation manager said that he had overheard prisoners shouting

out the windows at the man, “egging him on” and telling him to do things like “go on, do a dirty protest”. This was a frequent occurrence. He never heard any prisoners telling the man to harm himself.

244. All prisoners interviewed were convinced that the man was suffering from poor mental health. In their opinion, to sustain the level of noise and disruption for such extensive periods of time would have required some level of mental illness. Those who had brief conversations with the man through the windows said that he told them he was depressed, unhappy and annoyed at being at Long Lartin. However, he never talked about wanting to harm himself.
245. My investigator and her assistant asked interviewees if they had noticed any difference in staff care since the man’s death. A couple of prisoners said that since his death a few prisoners in the segregation unit had been given televisions and that the response to cell bells was quicker.
246. The prisoners’ reaction to the man’s constant disruption was not generous but perhaps unsurprising. Those who suggested that staff drove the man to his death did not provide any credible evidence. In particular, I believe the officer who asked for a response from the man when he blocked his observation panel was right to do so. As I have frequently pointed out in my reports, although it is a mainstream feature of prison culture the obscuring of observation panels has evident implications for both safety and security.

### **Sentence planning**

247. Despite being a life sentenced prisoner and having been sentenced on 10 October 2006, the man had never received a sentence plan. The purpose of the life sentence plan is to map out, monitor and record the means by which each prisoner is supported to achieve a reduction in risk such that he or she may safely be released on licence at tariff expiry. All sentenced prisoners would expect to have a sentence plan to work through within three months of sentencing. This did not happen in the man’s case at Long Lartin. His probation officer told my investigator that she did not see any sentence planning documents on his transfer from Belmarsh. After interview, the probation officer contacted my investigator by letter and said that the man had a sentence planning board arranged for 25 January 2007. The board did not take place. She believed that all the boards for that afternoon were cancelled, but could not confidently provide a reason. The probation officer did not say whether another board had been scheduled.

**The Governor at Long Lartin should satisfy himself that when sentence planning boards are cancelled another is rescheduled at the earliest opportunity.**

### **Mental health**

247. Two clinical reviewers produced a thorough clinical review into the man’s care on behalf of Worcestershire Primary Care Trust. Joint interviews were held

with my investigators. The clinical review can be found in full at annex 1. I have summarised the clinical review findings below.

248. The clinical reviewer's broad conclusion is that there were no identifiable lapses or failures of care leading to the man's death. The man was an aggressive, manipulative, withdrawn and difficult individual whose behaviour made his care and custody challenging. His suicide was not predictable and the immediate response to it appropriate. A more structured approach to learning from events like this and greater clarity of responsibility could improve healthcare at the prison.

### *Medical history*

249. The man was young with no significant physical health issues. He had a history of substance and alcohol misuse from his early teens, in addition to violent and anti-social behaviour.

250. The man's mental health history has been extensively reviewed. In summary, it was held that historical accounts of his behaviour, his presentation in clinical settings and his performance in psychometric testing overwhelmingly indicate that he was suffering from an anti-social personality disorder with emotional unstable and probably sadistic traits. A history of substance misuse and possible autistic spectrum disorder were also relevant.

251. The possibility that the man also suffered from a mental illness had been raised. Assessment of this possibility was complicated by inconsistencies in his presentation and suggestion that his symptoms were exaggerated or fabricated. He was held for a time at the JHC with the intention of clarifying his diagnosis and had been considered for admission to Broadmoor while at Long Lartin.

### *Key Findings*

#### *Were the man's mental health problems comprehensively assessed and managed?*

252. The man's mental health issues were complex and his diagnosis was not yet fully resolved. The clinical review concludes that the man's mental health problems were comprehensively assessed. He was seen by a number of forensic psychiatrists and continued to be reviewed at Long Lartin. He was under ongoing review by Broadmoor.

253. The clinical reviewer was keen to establish whether the uncertainty over the man's diagnosis was reasonable given the nature of his behaviour and custodial situation. He and another clinical reviewer found this to be the case.

254. The clinical reviewer was initially concerned that Broadmoor acknowledged the value of a full inpatient assessment of the man but had not made a place available. The clinical reviewer is satisfied that:

“This was justifiable in terms of the likely settling and evolution of [the man’s] symptoms, allowing the natural history of his problems to clarify, and the risks of an early admission provoking further behavioural responses from [the man] that would obscure his true symptomatology.”

255. The clinical reviewer notes that, for a time, the man was treated with anti-psychotic drugs and then explicitly taken off them. The review concludes that it was satisfactory these were discontinued due to non-compliance and there was not a case for enforcing medication.

256. The clinical review notes that the man was “socially withdrawn, exhibited bizarre behaviour and was engaged in 'dirty-protest' at times while at HMP Long Lartin and HMP Belmarsh.” He was not easy to assess and this was exacerbated by the custodial regime that his behaviour prompted. The clinical reviewer says:

“... while this cannot have helped [the man’s] mental state it is not clear that custodial or healthcare staff could have done much that would have effectively supported [the man’s] 'normalisation' and perhaps have taken him further away from the mental state in which he decided to take his own life.”

257. The clinical reviewer comments it would have been good practice to have seen evidence of a clear and regularly reviewed mental health management plan, an equivalent to a Care Programme. Although the man may not have been suffering from a severe and enduring mental health problem, the complexity and difficulties he presented might have suggested that such an approach could have been beneficial. As an example, it had been suggested that the man might have had autistic spectrum disorder and a care plan would have made clear if and when he was to be appropriately tested for this.

*Were indications of a risk of self-harm identified and appropriately acted upon?*

258. The man had previously self-harmed while in custody. The evidence suggests that, other than this occasion of ligaturing in January 2005, he did not raise concerns of suicide risk. The clinical reviewer concludes, “there is no obvious temporal or situational trigger to explain why he took his own life at the time and place that he did.”

259. As at all prisons, Long Lartin has sophisticated procedures in place for the assessment and monitoring of suicide risk (ACCT). For a time, the man was monitored under the ACCT process, though this had been used to provide a monitoring framework for the psychiatrist rather than because of a fear that he might commit suicide. There is no evidence to suggest that custodial or healthcare staff failed to identify any signs that might have prevented his suicide.

260. It was put to the clinical reviewer and my investigators during interviews that the man's state was felt to be improving in the period immediately leading up to his suicide. It had been agreed that his observation book could be discontinued.

There is no objective measurement of the man's mental state available and it appears that this improvement was an impression sustained through discussion in weekly multi-disciplinary meetings.

*Was communication amongst those responsible for the prisoner's care satisfactory?*

261. There is considerable risk of communication problems in the care of people who move between institutions and are cared for by a wide range of professionals over a long period of time. The clinical reviewer finds no evidence of communication failure contributing to the man's death. It is noticeable, however, that the comprehensiveness and coherence of the reports made on the man's mental health at the time of his trial are far beyond what his prison medical record provides.
262. The weekly multi-disciplinary mental health team meetings at HMP Long Lartin provide the means of information sharing amongst healthcare staff. It is important that these meetings are structured and minuted and that decisions are fed back into patients' care plans.
263. The clinical review finds that communications might be improved. For example, during the investigation Broadmoor made contact with the mental health team at Long Lartin to organise a further review. They had not been told of the man's death. While this is not a damaging failure of communication, it illustrates a lack of clarity about the co-ordination and responsibility for this man's care.

*Was the clinical response to the fatal incident appropriate?*

264. The review finds that the clinical response to the discovery of the man in his cell on 1 April 2007 was appropriate and satisfactory. Healthcare staff were summoned, they assessed the man, and cardio pulmonary resuscitation was carried out. An ambulance was called. It does not appear to either the clinical reviewer or myself that anything more could have been done to have prevented the man's death. The evidence presented to the clinical reviewer and my investigators suggests that he was probably dead by the time he was discovered. It was not clear whether the call for an ambulance was procedural or the exercise of common sense.
265. The clinical reviewer says that, in view of the increased risk of self-harm amongst prisoners, the ageing population at Long Lartin and the difficulties in access for healthcare staff (including ambulance paramedics), training of custodial staff in cardio pulmonary resuscitation should be considered.

*Was the organisational response to the man's death appropriate and likely to lead to lessons being learned and acted upon?*

266. The clinical review finds that healthcare staff at HMP Long Lartin had identified lessons learned and that some change had resulted from this. However, the response to lessons learned was less structured and more dependent on informal communications and networks than the reviewer considers ideal. For

example, some staff have access to a clinical psychologist with whom they could discuss issues and obtain professional support, but links to changes in practice beyond the individual level have not been embedded.

267. During interview, my investigators and the clinical review team were told that there had been an improvement in the level of communication since the man's death, but they saw no evidence of change in written procedure or the structure for communication amongst the healthcare teams. It would have been good to have seen written evidence of systematic reflection and learning and, where appropriate, changes in process.
268. The man's death was clearly a great shock to those involved in his care. There appeared to be a lot of reflection in response. It was evident that efforts were made to offer staff support, but these appear to have been reactive rather than planned.

### *Mental health teams*

269. A primary care team and an in-reach team provide mental health care at Long Lartin. This is the situation at most prisons. South Worcestershire Primary Care Trust and Worcestershire Partnership Trust are the providers. Both teams offer the same kind of care and support, but the support of the in-reach team is more intense and longer-term. The in-reach mental health team has specific referral criteria - prisoners with severe and enduring mental health illnesses who are under a care programme approach (CPA): a managed approach that is capable of offering joined-up care between the community and prison. The goal of the in-reach team is to help the individual manage their mental illness and live as normal a life as possible. The equivalent in the community would be for the individual to be able to live at home rather than in hospital.
270. The in-reach team at Long Lartin consists of a manager (a psychiatric nurse), a full time CPN and an occupational therapist. The manager is responsible for another team at HMP Blakenhurst and accordingly splits her time between the two prisons.
271. Patients are referred to the in-reach team after an initial assessment by the primary care team. The urgency of the referral is based on the severity of the prisoner's presentation. Psychiatric care is provided by the Reaside Clinic. All three strands of care feed into each and information sharing takes place at weekly multi-disciplinary meetings. During his time at Long Lartin, all three teams cared for the man at different stages. The man was referred to the in-reach team by his CPN due to concerns about his mental health history. The in-reach team accepted him on their caseload with continued input from the registered mental health nurse, but discharged him once Broadmoor declined to admit him as a patient. On discharge, the man remained under this nurse's care. The psychiatric care remained consistent. As a patient of the primary care team, the man would have benefited from greater and more frequent contact with his CPN. He should have been seen daily by a member of the primary care team, whereas in-reach has fewer staff.

272. When clinical responsibility is changed or shared it is good practice to document this clearly e.g. whether primary care or in-reach is the co-ordinator for the care. In this instance, it was not clear who was lead co-ordinator.

**Worcestershire Primary Care Trust should remind staff to keep a clear record of who has clinical responsibility for a patient when transferring between primary care and mental health in-reach, especially where care is shared between the teams.**

273. The decision to have both primary care and in-reach input is worked out on an individual case basis. The reasoning for this in the man's case was because he was complicated and both teams wanted a clear diagnosis. There does not appear to have been a clear structure for sharing the case, aside from information sharing at the weekly meetings. Equally, there does not seem to be any reason for the retraction of in-reach intervention aside from Broadmoor declining to admit the man. There was continued psychiatric input and assessment for both close supervision centre referral and at the request of the forensic psychiatrist.
274. Prisoners on the segregation unit see one of the primary care CPNs daily, and a doctor three times a week. The CPN check is a cursory assessment. If the prisoner wants to speak further to the nurse, the time is made available or they are referred to their allocated CPN unless they are under the care of the in-reach team, in which case the team is notified. Contact with the in-reach team is minimal compared to that with the primary care team. The in-reach team will see a patient either on a weekly or fortnightly basis. On being asked why the man was removed from the in-reach team's case-load, The CPN from the in reach team said:

“Basically I think the reasons were that he wasn't going to be offered a bed to be re-admitted to Broadmoor. They said there was no clear diagnosis with the man either and he wasn't engaging with us and one of the recommendations from the doctor from Broadmoor was that he should continue to be monitored, ongoing monitoring, which we felt possibly was better from primary care because they, we were seeing this man once a fortnight and it was felt that they would have more access to the man because there's a nurse that goes there everyday to do more a complex assessment.”

275. I am not persuaded that this was a satisfactory reason to remove a patient from the in-reach caseload when the man required more intense and frequent monitoring for his next Broadmoor assessment. The CPN from the inreach team said that she did not feel comfortable discussing the confusion over his diagnosis, saying she had only seen him six to eight times and it was something for the psychiatrist to comment on.
275. The two teams meet on a weekly basis to discuss new referrals and existing caseloads. Any action, progress or deterioration is noted in the minutes. Not all patients are discussed every week. From February 13 to 20 March 2007,

the man did not feature in the weekly meeting discussions. There was a short entry in the minutes on 20 March 2007 to say that the man's behaviour had improved over the last two to three weeks and that the observation book (for monitoring his mental health) could be closed. Despite the fact he was not being re-referred to Broadmoor, the man was seen regularly by his CPN and the psychiatrist. It is surprising that he was not discussed during these meetings given the level of supervision and observation he was under.

276. On the whole, staff from both mental health teams said these meetings work well and are useful. However, I think there would be merit in having the segregation unit manager present when discussing prisoners under his/her care. This would allow for an additional perspective on a prisoner's presentation for the week and help foster better communication on issues relevant for both sets of staff. Staff on the segregation unit would welcome a better insight into the mental health of the prisoners for whom they are responsible. I appreciate that the issue of medical confidentiality may make this complicated to implement. However, I think it would be helpful for the unit manager to be present at the meetings and thus develop a greater understanding of the nature of the prisoners on the unit.

**Consideration should be given to including the segregation unit manager, or a similar representative during the weekly mental health clinical meeting.**

277. There were conflicting opinions as to what was wrong with the man. He was never formally diagnosed with a personality disorder or as suffering a psychotic illness. The belief of both the in-reach team and Broadmoor was that he did not present as psychotic. However, the psychiatrist did think that he presented as psychotic at times and was assessing him for further referral to Broadmoor. The psychiatrist told my investigator and the clinical reviewer that the man was generally not keen to be seen by him. His impression of the man was based on a limited amount of time (weekly meetings). Towards the beginning of their interactions the psychiatrist was able to make a relatively comprehensive assessment. However, he was unable to sum up his personality in that time and decided that he needed a more thorough assessment.
278. As previously mentioned, the man's medical record did not immediately follow him from Belmarsh to Long Lartin. The psychiatrist did not have the man's full medical record available at the time of the initial psychiatric assessment. He did have the discharge letter from the JHC and a referral from the mental health team leader. I repeat that it is unacceptable that a prison receiving a prisoner who is known to be difficult to care for is not fully briefed before their arrival. It is equally unacceptable that the medical record is not available immediately. Not having such crucial information makes continuity of care nigh on impossible. The psychiatrist had to make his assessment without reference to the man's recent care at Belmarsh. He made an independent assessment based on the man's presentation at the time, and this appeared to show psychotic symptoms that needed treating. The psychiatrist restarted the man's prescription of aripiprazole. He was under the impression that the man was

receiving medication at Belmarsh prior to his transfer. This was not the case. His medication had never been resumed on return from Belmarsh.

**Offender Health should consider how best to ensure that, when a prisoner is transferred between prisons, the releasing healthcare department arranges that the full medical record for any prisoner with a history of mental illness is made available to the receiving prison at the earliest point.**

279. The man took one dose of the medication he had re-started, then refused to take any more. Staff told the psychiatrist that they had overheard the man say to a prisoner "I am stopping my medication because I want to get ill." The psychiatrist had made a note of this in the man's medical record on 17 November 2006. He explained to my investigator that this could have meant one of two things. Either the man was becoming mentally ill or that he was not ill but knew that he would be if he stopped his medication. There was insufficient evidence in any other documentation to confirm that the man had made this statement.
280. The clinical reviewer asked the psychiatrist whether it was unusual to have conflicting opinions over a mental health diagnosis, such as in the man's case. The psychiatrist explained that it is fairly common for people to suffer from a severe and enduring illness such as schizophrenia in conjunction with a personality disorder. The symptoms of both illnesses can be intermittent. It was further explained that some doctors do not regard intermittent psychotic symptoms as compatible with a diagnosis of personality disorder. Such conflicting opinions cause difficulties in making a firm diagnosis. The psychiatrist believed that the forensic psychiatrist's assessment was not that the man did not suffer from a psychotic illness. It was more a question of how best to manage him given his presentation at the time of assessment and based on the feedback from the John Howard Centre. The combination of both did not at that time meet the requirements for referral to Broadmoor but did warrant further observation over a longer period of time before committing to a hospital admission. The forensic psychiatrist wanted this to happen at Long Lartin and intended to return to assess the man in early May 2007.
281. In the meantime, the psychiatrist asked staff to closely monitor the man to gather more information for the forensic psychiatrist from Broadmoor. This was initially done using an ACCT form as an observation tool and later an observation book. Both were utilised effectively by staff and quality entries were made on a daily basis to the best of their ability given the man's limited engagement. Although an ACCT form was used, there was never an active concern that the man would self-harm or commit suicide.
282. The MHIRT nurse told my investigator that when information was crucial to staff or prisoner safety, details about a prisoner's mental health would be shared. My investigator asked this nurse if basic information such as how to get the best response from a prisoner or how to work with them to improve engagement and progress could be shared with officers. This nurse said that

in-house mental health awareness training is on offer to officers and this would help them deal with prisoners with impaired mental health.

283. The Chief Inspector of Prisons' thematic review of the care and support of prisoners with mental health needs, mentioned earlier in this report, refers to the need for increased joint working between mental healthcare services and staff in prisons: the goal being to ensure the delivery of coordinated care and management for each individual prisoner. Segregation unit staff at Long Lartin echo this. It was stressed to my investigator that there is a need for improved coordinated care due to the nature of the prisoners who are based on the unit. Increasingly, prisoners with mental health problems are placed in their care and staff said that they do not feel adequately equipped to best manage their needs. Whilst there is good support from both primary care and in-reach teams, staff said there was a high demand for having a permanently based RMN or CPN on the segregation unit. Given that in the last year there have been two self-inflicted deaths of prisoners with serious mental health problems in the segregation unit, I strongly support this request by staff.
284. The Chief Inspector's review makes reference to the importance of ensuring that discipline staff receive quality controlled mental health awareness training, with at least bi-annual updates. I agree and would urge the Prison Service, in conjunction with PCTs, to provide ongoing mental health awareness training for discipline staff, particularly those who are required to care for prisoners on segregation.

**The Governor and Worcestershire Primary Care Trust should ensure that all discipline staff in the segregation unit have access to regular mental health awareness training.**

#### *Aftercare for staff*

285. The psychiatrist was informed about the man's death by email. The information he was given was sparse and he had to telephone the healthcare manager for fuller details. He was no longer working at the prison at the time of the man's death as his year long contract had come to an end. Given the time and input this psychiatrist had in the man's care, I think this was less than sensitive. The psychiatrist told my investigator that he was surprised by the man's death, but recognised that statistically he was at high risk. The psychiatrist felt that the man always presented as being a greater threat to others than to himself.

**The Governor at Long Lartin should review arrangements to ensure that key staff and practitioners involved in a prisoner's care are appropriately informed of a death in a timely and appropriate manner.**

#### *The role of the PCT as commissioner*

286. The clinical review highlights that South Worcestershire PCT commissions and provides healthcare at Long Lartin. The reviewer feels that full opportunity is not being taken to ensure independence and accountability in the system as the PCT carries out both functions. He recommends that the PCT review its

prison health commissioner functions to ensure that it has the independence and clinical credibility required. This would, for example, provide confidence that there is no 'gap' in provision for prisoners deemed not to have a severe and enduring mental health problem requiring specialist forensic psychiatric input, but who need general psychiatric input beyond what the primary care team can provide.

## CONCLUSION

287. The man's behaviour during his time in custody was challenging, particularly during the last six months of his life. He required intensive input from staff. Even simple things like unlocking him for a shower required locking down the rest of the wing and having up to six staff in full personal protective equipment to move him.
288. The segregation unit is not an ideal environment for those with mental health problems or whose behaviour is bizarre. It is not a psychiatric hospital and the staff are not trained psychiatric nurses. The clinical reviewer says that, ideally, the man should have been in psychiatric facility for assessment. However, Broadmoor would not take him without further analysis. The man remained in the segregation unit as Long Lartin's healthcare inpatient facility was simply not suitable.
289. There were brief periods during which he would engage positively with staff and some prisoners, especially during March 2007. The man had indicated that he wanted to make contact with his family and was beginning to show more responsible and consistent behaviour. His attitude was less threatening and staff started to think that with more effort he might be able to progress from the segregation unit. Unfortunately, his behaviour deteriorated from 26 March 2007 and, after a further period of dirty protest, he took his own life. There was no indication that the man was feeling unusually depressed or was especially at risk of self-harm. Despite his erratic and bizarre behaviour, his death came as a shock to staff.
290. I believe that staff at Long Lartin and Belmarsh prisons managed the man to the best of their ability within limited resources. I commend those involved in his care for attempting to engage with him and for their persistence in trying to get him to settle down and progress. The man was by no means an easy prisoner to work with and he was often violent or abusive. A great deal of patience was required from both staff and prisoners alike, particularly at Long Lartin. Despite the man's difficult and troubled personality, there were those who saw potential for him to progress and who were saddened by his death. The imam said that the man described himself as a "broken man" who did not want to be seen in this way.
291. It has not been possible to conclude whether the man's actions were a cry for help or intentional. My investigation has demonstrated that staff in both Belmarsh and Long Lartin handled his immediate needs appropriately given the constraints within the prison system for managing prisoners like this man. However, I have some concerns around the management of his longer-term needs and have recommended areas for improvement in mental healthcare provision, the segregation unit regime and transfer between prisons.

## RESPONSE TO THE DRAFT REPORT

292. The Prison Service and the man's family have had the opportunity to consider the draft report. No corrections or amendments have been suggested by either party. The Prison Service has not yet provided an action plan or response to the recommendations in this report.
293. Worcestershire PCT and Mental Health Partnership NHS Trust (MHPT) have responded to recommendations 1, 3, 6, 7, 8 & 9. The summarised responses can be found on page 70 and more detailed comments from the MHPT are inserted at Annex 8.
294. In addition, the PCT and MHPT have provided information regarding commissioning the Care Services Improved Partnership (CSIP) to undertake a review of prison health services. The detail of which is as follows:

“Earlier this year the PCT commissioned CSIP to undertake a review of prison health services. The recommendations provide the basis for a long term project (12 months) to develop prison health care services in terms of both provision and commissioning. The aim is that all aspects of prison health care are fully embedded in the PCT performance framework. This project will drive sustainable improvements in prison health care services.

The project will also provide a vehicle for ensuring that the lessons learnt and key recommendations from inquests and Prison and Probation Ombudsman reports over the past 12 months are addressed in a comprehensive manner.

Coordination of the 3 strands of mental health input is a key element which threads through the report on this tragic young man. To begin the process of improved coordination the Worcestershire Mental Health Partnership Trust has been invited to joint the Worcestershire Prison Health Partnership Board. Worcestershire PCT provider arm is also working with the MHPT to identify and address gaps in current mental health service provision. The PCT has identified funding within the Operating Plan for 2008/2011 to support the development of prison health services.”

295. I welcome the PCT and MHPT's enthusiasm for taking these recommendations forward and developing a more integrated and coordinated response to prisoners with mental health needs in their area.

## RECOMMENDATIONS

1. The Governor at Long Lartin should consider how best to ensure that all staff are fully briefed before receiving prisoners with a history of mental illness.

*Worcestershire PCT would support the need for timely communications at all levels regarding the health care needs of transferring prisoners. This is particularly cogent for individuals with complex physical or mental health needs.*

2. The Governor at Belmarsh should remind staff of the Prison Service Order 1700 (Segregation) requirement that all prisoners, with the exception of category A and E list prisoners, are informed if they are to be transferred to another establishment and told where they will go.
3. Worcestershire Primary Care Trust and the Governor at Long Lartin should consider allocating the equivalent of a full-time registered mental health nurse to the segregation unit.

*Worcestershire PCT accepts that prisoners within the segregation unit may have greater mental health needs. While a dedicated RMN post has been agreed in principle more detailed work is being undertaken to scope the requirements of this role and the necessary support arrangements.*

4. The Governor at Long Lartin should remind staff and Duty Governors involved in instances of use of force to check and sign paperwork at the earliest opportunity.
5. The Governor at Long Lartin should satisfy himself that when sentence planning boards are cancelled another is rescheduled at the earliest opportunity.
6. The Worcestershire Primary Care Trust at Long Lartin should remind staff to keep a clear record of who has clinical responsibility for a patient when transferring between primary care and mental health in-reach, especially where care is shared between the teams.

*The PCT would support the principle that clarity is required at all times on who has clinical responsibility for an individual patient.*

*In this case clinical responsibility was passed from the MHIRT to the primary care team (page 37, paragraph 148), however, the rationale for this was not clearly documented. The PCT would suggest that as good practice that the rationale for changes in clinical responsibility should be clearly documented.*

7. Consideration should be given to including the segregation unit manager or a similar representative during the weekly mental health clinical meeting.

*Involvement of the segregation unit manager in weekly mental health clinical meetings is a positive means of ensuring that all staff are fully appraised of risks and understand the approach being taken to meet the care needs of*

*individual prisoners. Due attention will need to be given to any confidentiality issues.*

8. Offender Health should consider how best to ensure that, when a prisoner is transferred between prisons, the releasing healthcare department arranges that the full medical record for any prisoner with a history of mental illness is made available to the receiving prison at the earliest point.

The PCT's response is the same as that for recommendation 1.

9. The Governor and Worcestershire Primary Care Trust should ensure that all discipline staff in the segregation unit have access to regular mental health awareness training.

*Regular mental health awareness training for segregation unit staff is supported by the PCT. Training has been arranged for September in the Mental Health partnership Trust.*

10. The Governor at Long Lartin should review arrangements to ensure that key staff and practitioners involved in a prisoner's care are appropriately informed of a death in a timely and appropriate manner.