

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Ms Joanne Latham a prisoner at HMP Woodhill on 27 November 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

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

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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

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

Ms Joanne Latham was found hanged in her cell at HMP Woodhill on 27 November 2015. She was 38 years old. I offer my condolences to Ms Latham's family and friends.

Ms Latham was born male but, four months before her death, had asked to live as a woman. The appropriate allocation of transgender prisoners is not straightforward and national policy is currently under review. However, I am generally satisfied that Woodhill responded appropriately to Ms Latham's request to be treated as a transgender prisoner and we have respected her choice in this report. Ms Latham had a very violent history and had spent a number of years in a high security psychiatric hospital. She often self-harmed. Since May 2014, she had been held in the close supervision centre at Woodhill, part of a national system for managing the most disruptive and dangerous prisoners.

Ms Latham was being monitored under Prison Service suicide and self-harm prevention procedures at the time of her death. I am concerned that these procedures did not operate fully effectively and the frequency of observations did not reflect her high risk at the time. While I recognise that Ms Latham was regarded as a high risk of violence towards staff, as well as to herself, I consider that it took prison staff too long to go into her cell after she had barricaded it, seriously self-harmed, and then did not respond at a welfare check. National and local guidance to deal with cell barricades were not followed. Sadly, when staff eventually intervened, it was too late to save Ms Latham.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**August 2016**

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# Summary

## Events

1. On 10 May 2001, Mr Edward Latham was sentenced to life imprisonment. He had a long history of self-harm and mental health problems, including anti-social and borderline personality disorder. He had spent some years in Rampton Hospital from where he was discharged in 2013. In May 2014, Mr Latham was transferred to the close supervision centre at HMP Woodhill. He was often monitored under suicide and self-harm prevention procedures (known as ACCT).
2. In August 2015, Mr Latham asked to be considered as transgender. (From this point, we recognise her identity as Ms Latham, in line with her wishes.) A psychiatrist referred her to a specialist gender clinic and she started to live as a woman.
3. On 11 November 2015, there was a delay with Ms Latham receiving make-up brushes she had ordered, while the security department checked and cleared them. Ms Latham became very upset about this. On 19 November, staff ended ACCT monitoring after she appeared more settled, although she had still not received the make-up brushes.
4. On 25 November, an officer told Ms Latham that she would receive the make-up brushes the next day. However, this did not happen, as a security meeting decided that the brushes should be photographed first. Ms Latham reacted to this aggressively and threatened to harm staff and herself. Staff began ACCT procedures again on 26 November, and assessed that she was a raised risk of suicide and self-harm. They set observations at once an hour during the day and five checks during the night.
5. Over the course of the day, Ms Latham became more threatening and aggressive. At 7.55pm, an officer found that she had barricaded her cell door and blocked her observation panel. That evening, Ms Latham self-harmed by making at least one small cut on her wrist. At 12.30am on 27 November, Ms Latham showed the night manager that she had cut her arm very seriously. Observations were increased to twice an hour. The night manager did not call additional staff to remove the barricade and go into the cell. Ms Latham said she would cooperate if she was given tobacco but the manager refused this.
6. At 4.30am on 27 November, Ms Latham did not respond when an officer checked her and he radioed for help. Other staff, including a nurse, arrived and waited until the night manager arrived at 5.16am, with tools to open the cell door outwards. The officers had still not got any response from Ms Latham. At 5.26am, they opened the cell door, removed the barricade made of cell furniture and found Ms Latham hanged. Staff and paramedics tried to resuscitate her. At 6.20am, paramedics recorded that she had died.

## Findings

7. Ms Latham had been assessed as at risk of suicide and self-harm and had actively self-harmed on the night of 26/27 November. We consider that staff should have intervened earlier when she covered her door observation panel and

barricaded herself in her cell, particularly after she cut herself severely at 12.30am. We recognise that Ms Latham was potentially very violent and do not underestimate the risk to staff, but no one implemented the prison's contingency plans for dealing with barricade incidents or followed the national instructions. Partly, this was caused by a failure of communication between the managers responsible for the operation of the prison that evening and later that night.

8. There were also failings to manage the ACCT procedures effectively to protect Ms Latham. Although Ms Latham was regarded as a raised risk, observations were set originally at only five times during the night, even though she had cut herself. Staff checked her at predictable intervals. After she later self-harmed very seriously, we consider she should have been regarded as at high risk with very frequent, if not constant, observations, but these were raised to only twice an hour. ACCT case reviews did not fully examine the reasons behind Ms Latham's distress or take active steps through effective caremaps to address her concerns and help reduce her risk.
9. We are satisfied that Ms Latham received appropriate mental health support at the prison, equivalent to the care she could have expected in the community. Ms Latham had only recently decided to live as a woman at Woodhill. Although security clearance of make-up brushes took an unnecessarily long time, we consider that she received mostly appropriate support for transgender issues.

## Recommendations

- The Governor should ensure that staff follow local instructions to manage situations when prisoners barricade their cells and take all reasonable steps to gain access to a barricaded cell quickly, particularly when the prisoner is assessed as at risk of suicide and self-harm.
- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
  - A trained ACCT assessor should complete an assessment within 24 hours of the ACCT being opened, using all available information if the prisoner refuses to engage.
  - ACCT case reviews should assess the level of risk taking into account all risk factors.
  - Levels of observations should reflect the risk and staff should carry out and record all required observations at unpredictable intervals.
  - Case managers should review progress against caremaps at each review and not close ACCT plans until caremap actions have been completed.
- The Governor should ensure that all staff who work in the CSC, have appropriate training and that all managers who have responsibility for the CSC at night and other times are appropriately trained and equipped to manage incidents in the CSC.
- The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities in a medical emergency, including bringing relevant equipment immediately. Unless there are clear signs of death, staff should administer and continue basic life support until paramedics arrive.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Woodhill on 2 December 2015. He obtained copies of relevant extracts from Ms Latham's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Ms Latham's clinical care at the prison.
13. The investigator interviewed one prisoner and 18 members of staff at Woodhill in February 2016, some jointly with the clinical reviewer.
14. We informed HM Coroner for Milton Keynes of the investigation and have sent him a copy of this report.
15. Ms Latham was born male. By law, she was still male at the time of her death, but had asked to live as a woman at Woodhill four months earlier. We have referred to her by her preferred name and gender, in line with the Department of Health's guidance for transgender persons and to respect her wish to be referred to as a woman.
16. One of the Ombudsman's family liaison officers contacted Ms Latham's family at the beginning of the investigation and they said that they would like a copy of the initial report. Ms Latham's family were contacted by phone and letter to inform them that the report was ready; it was however not requested during the timeframe provided.

## Background Information

### HMP Woodhill

17. HMP Woodhill is both a local prison and a high security prison. It can hold more than 800 men. Oxford Health Foundation Trust provides primary and secondary mental health services in the prison's close supervision centre (CSC). Central North West London Mental Health Foundation Trust provides emergency, out of hours mental health care in the CSC.

### HM Inspectorate of Prisons

18. The most recent inspection of HMP Woodhill was in September 2015. Inspectors did not inspect the CSC during this inspection or their previous one in January 2014.
19. The last inspection of the CSC took place in January 2012. At that time, inspectors found that staff dealt well with extremely challenging and dangerous prisoners in difficult circumstances. They noted that relationships between staff and prisoners appeared good, and that staff were well informed of CSC prisoners' personal circumstances and security issues.
20. At the 2012 inspection, inspectors found that ACCT records were mostly of reasonable quality but procedures were poor, with some serious weaknesses in the way some prisoners at risk were managed. Inspectors recommended training and better management oversight to improve the quality of ACCT assessments, reviews, and case management.

### Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2015, the IMB noted that staff needed more training to help improve the management of prisoners being monitored under ACCT procedures. The IMB noted that relationships between staff and prisoners in the CSC were strong, which helped prisoners feel secure.

### Previous deaths at HMP Woodhill

22. Before Ms Latham's death, there had been five self-inflicted deaths at Woodhill since January 2014. There have been six further deaths since Ms Latham's death, four of which were apparently self-inflicted. In this report and in the five previous reports, we identified deficiencies in the quality of ACCT procedures.

### Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should

be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **Close Supervision Centres**

26. The close supervision centre (CSC) system holds about 60 of the most dangerous prisoners in England and Wales. Many have been imprisoned for very serious offences, have usually committed subsequent serious offences, and their dangerous and disruptive behaviour is difficult to manage in standard prison locations. They are held in small units throughout the high security estate. The system is run by a central team as part of the Prison Service's high security directorate but day-to-day management is the responsibility of the individual prisons, with the aim of reducing the risk the prisoners pose to themselves and others.
27. At Woodhill, dynamic risk assessment meetings (DRAM) are held weekly in the CSC to consider the regime and unlocking arrangements for each of the prisoners in the CSC. A multi-disciplinary team attends the meetings. The DRAM meetings aim to identify and discuss key changes to a prisoner's risk and/or behaviour. The meetings also cover other matters such as prisoners' requests for access to specific items.

### **Transgender prisoners**

28. Prison Service Instruction (PSI) 07/2011 on the care and management of transgender prisoners, covers medical treatment, living in an acquired gender role and the legal position for doing so. Gender reassignment is a protected characteristic under the Equality Act 2010, and prisoners must not be discriminated against or harassed because of it.
29. The national instruction says that governors must allow prisoners who consider themselves transgender and who wish to begin gender reassignment to live permanently in their acquired gender. This includes allowing them to dress in clothes appropriate to their acquired gender, use gender appropriate names and access the items they use to maintain their gender appearance at all times.

## Key Events

30. On 10 May 2001, Mr Edward Latham (who later changed identity to Ms Joanne Latham) received a life sentence for attempted murder. In 2007 and 2012, he was convicted of two further attempted murders at HMP Frankland and at a high security psychiatric hospital, where he was held between 2007 and 2013. Mr Latham showed no remorse and said he never wanted to be released. He had a long history of mental health problems and serious self-harm.
31. On 24 September 2013, Mr Latham was discharged from the high security psychiatric prison to HMP Full Sutton. Within days of arriving, he seriously self-harmed. Staff began ACCT procedures and observed him constantly. Mr Latham told staff that he would seriously harm a member of staff, unless he was transferred to a close supervision centre (CSC). Staff noted that he was a prolific self-harmer and made weapons to stab himself and others. His behaviour was extremely unpredictable and challenging. In May 2014, he threatened to barricade his cell and kill himself if he was not transferred to Woodhill.
32. On 27 May 2014, Mr Latham transferred to the CSC at Woodhill. During his assessment period, his behaviour fluctuated. He continued to threaten staff and self-harm. Staff assessed that there was a risk that Mr Latham might attack someone at any time, with the intention of killing them or causing serious harm.
33. Mr Latham had been diagnosed with anti-social, borderline and paranoid personality disorder. He also suffered from anxiety disorder. He isolated himself and did not comply with the prison regime, interventions or take part in therapy. The CSC's mental health team assessed Mr Latham frequently and he saw the unit's resident forensic consultant psychiatrist often. Mr Latham was prescribed clonazepam and pregabalin for anxiety. On 13 October 2014, Mr Latham completed his assessment period and remained in the CSC.
34. On 11 March 2015, Mr Latham told staff that he wanted to become a Muslim and made plans to change his name. However, on 12 June, he asked an officer to change the records of his religion from Muslim to no religion.
35. On 24 April, Mr Latham was moved to HMP Manchester for a period of accumulated visits (which allow prisoners who are some distance from their home to move to a prison close to their family for a short period for visits). On 4 May, Mr Latham swallowed five AA batteries and was admitted to hospital. The batteries were removed on 6 May by an endoscopy procedure and Mr Latham returned to the prison the same day. He told a nurse that he had just learnt from a relative that his brother had died two years earlier. At first, he was constantly observed and then observations were reduced to hourly on 13 May. He returned to Woodhill on 15 May.
36. Between May 2014 and June 2015, Mr Latham was monitored under ACCT suicide and self-harm prevention procedures ten times, after incidents of serious self-harm and threats to kill himself. On 17 June, staff began ACCT procedures after Mr Latham cut his stomach. He said he was anxious after hearing about his brother's death, about a forthcoming court appearance (in connection with a civil action) and because he had no more tobacco. Mr Latham said he felt officers

were laughing at him and he refused to attend ACCT case reviews. Staff ended ACCT monitoring on 13 July.

37. On 3 August, Mr Latham told the CSC psychiatrist that he wanted to consider gender reassignment. The psychiatrist arranged to meet him the next week to discuss this. Mr Latham applied to be recognised as transgender and asked for access to women's clothing and cosmetics. (From this point, we recognise her identity as Ms Latham, in line with her wishes.) Over the following days, she made further applications to have cosmetics, a wig and other female products. Most were approved, but with some security restrictions.
38. On 10 August, the psychiatrist met Ms Latham to discuss her gender identity. Ms Latham said that she had felt she was a woman in a man's shell from childhood. She said she had once disclosed her feelings to a transgender friend and now felt liberated to discuss this. He referred Ms Latham to the Gender Identity Clinic, but warned her that the process would take months and possibly years.
39. On 13 August, Officer A noted that Ms Latham continued to ask for information about her transgender transition. She said that Ms Latham had talked to her about make-up and clothing and had seemed more settled after her decision to live as a woman.
40. The prison's diversity officer met Ms Latham several times to discuss her transgender issues and noted that she was demanding. The CSC mental health nurse spoke to Ms Latham about her gender transition and told her they would support her. On 20 August, an officer noted that Ms Latham found it difficult to accept how long it took to get the clothes and make-up she had asked for.
41. On 25 August, the mental health nurse noted that Ms Latham was frustrated about not getting immediate access to female accessories, but said she had no thoughts of harming herself. On 28 August, the prison formally approved Ms Latham's request to be referred to as Ms Joanne Latham.
42. On 7 September, Ms Latham told the psychiatrist and the mental health nurse that she had stopped seeing the psychologist, as she felt fine and did not want to work on issues to do with post-traumatic stress disorder. She said she was pleased she had disclosed her gender identity issues and wanted to pursue her referral to the gender transition clinic. The psychiatrist continued Ms Latham's prescription of pregabalin and clonazepam for anxiety.
43. On 1 October, at a mental health review, Ms Latham appeared agitated and told the mental health nurse that she wanted to transfer to another prison. She said if she stabbed someone, she would be moved to HMP Wakefield, but recognised that it would be difficult to be managed as a transgender prisoner, if she was moved around between segregation units, as a result. On 4 October, an officer recorded in Ms Latham's CSC report that because she had threatened staff, five officers had to be present to unlock her cell.
44. On 5 October, Ms Latham told the mental health nurse that she had tried on her make-up, but had not worn it outside her cell. The nurse noted that Ms Latham did not appear agitated or anxious. Over the following weeks, Ms Latham's general behaviour improved.

45. On 21 October, Ms Latham was abusive and hostile to a Supervising Officer (SO) because there had been delays giving her a box of make-up. Officers were concerned that Ms Latham might use parts of the box as a weapon. Ms Latham had refused the offer of having access to the make-up without the box.
46. On 27 October, Ms Latham accused the mental health nurse of being a spy and said that she would not engage with the mental health team. She said she had thoughts about attacking staff, but made no specific threats. The nurse told Ms Latham that there were no plans to move her to another prison and Ms Latham replied, "On their head be it". She noted that Ms Latham appeared irritable and lethargic and had reported fleeting thoughts of suicide, but said she had no plans to kill herself. Ms Latham said that she did not feel ACCT support would help her, because of her current relationship with staff and that the process would make her feel worse. The nurse offered support and arranged to see her again the next week.
47. On 1 November, an officer recorded in the CSC weekly report, that Ms Latham's risk had been reduced so that now they needed four officers present to unlock her, rather than five. She continued to apply for female items, appeared more patient and to accept that some requests might take longer than others. He noted that Ms Latham was polite and that her attitude had improved.
48. On 3 November, the mental health nurse noted that Ms Latham appeared in good spirits. Her solicitor was due to arrange for a private mental health assessment because she wanted to transfer to a psychiatric hospital, but Ms Latham accused the nurse of not supporting her transfer. The nurse planned to review her the next week.
49. On 5 November, the manager in charge of the CSC told Ms Latham that they had approved her request to have a bra with fillers, and jewellery. The next day, he sent a memorandum to CSC staff outlining how to manage Ms Latham's orders for women's items. In future, Ms Latham would need to get the agreement of the equalities team and the weekly dynamic risk assessment meeting before placing an order. Staff explained the process to Ms Latham.
50. On 6 November, an officer noted in Ms Latham's CSC report that her interaction with staff had improved but that she chose to spend most of the time in her cell. On 10 November, Ms Latham refused to do her cleaning work on the wing or to collect her meal (though she ate later). Ms Latham told an officer that she was upset that mental health staff were not supporting her request to transfer to a psychiatric hospital. He told her to discuss this with the mental health nurse. An officer discussed Ms Latham's change in behaviour with the other CSC staff and they agreed to monitor her more closely.
51. On 11 November, a set of make-up brushes, which Ms Latham had ordered, arrived in the CSC. An officer told Ms Latham that if the brushes were approved, she could have them but senior managers would have to agree this first. Ms Latham became aggressive, said it had nothing to do with the Governor and that officers were trying to prevent her having them.
52. The mental health nurse spoke to Ms Latham about her make-up brushes at a mental health review that day. She noted that Ms Latham was upset and

- accused staff of deliberately withholding the brushes. She explained that there was a clear procedure for approving items and that the issue could be resolved the next morning. Ms Latham said she was unhappy about this and that the matter would be resolved that night but would not say what she meant by that. Ms Latham turned down her offer to speak to her again the next morning.
53. The mental health nurse discussed Ms Latham with officers and they began ACCT procedures. They checked Ms Latham every half hour. Ms Latham was unhappy about this and said she would do something that would warrant ACCT procedures.
  54. On 12 November, Ms Latham refused to attend an assessment interview with an officer, as part of the ACCT process. She said all she wanted was her make-up brushes. She became loud and threatening, and swore at the staff. The officer told her that the dynamic risk assessment meeting would have to assess whether it was okay for her to have the brushes before she would be allowed them. He noted that Ms Latham said she “would have to do something”, but said she had no suicidal thoughts. (He later completed an assessment based on what Ms Latham had told him.)
  55. Staff held Ms Latham’s first ACCT case review, which she attended, although she had earlier refused to allow the officer to assess her. The SO noted that she engaged openly, and said she was concerned about not getting her make-up brushes. He told Ms Latham that she could not have the brushes until they had been approved at the risk assessment meeting. Ms Latham was not happy. Although she accepted the process, she said she might harm herself because of the way staff had treated her. He assessed Ms Latham’s risk of suicide as high, and instructed staff to continue checking her twice an hour. He noted as an action in Ms Latham’s caremap that the equalities’ team needed to clarify with Ms Latham when she would get her make-up brushes. They scheduled another case review for the next day.
  56. After the case review, the mental health nurse assessed Ms Latham, who said that staff did not challenge transphobic behaviour and that she was going to refuse to eat in protest. (There had been an incident the previous day when a prisoner had shouted out that staff should give Ms Latham her lipstick. The manager in charge of CSC had investigated the incident but concluded there was no evidence that the prisoner had made a derogatory comment.) The nurse noted that the primary healthcare team would monitor Ms Latham’s food intake.
  57. On 13 November, Ms Latham did not collect her lunch and told the mental health nurse that the prison was not following the correct procedures to deal with her food refusal. She told Ms Latham that the healthcare team was monitoring her appropriately, and reminded her that she had said she had eaten her breakfast the previous day. She told Ms Latham that she would ask the psychiatrist to review her on Monday 16 November.
  58. A SO and Officer A held an ACCT case review that day to which the mental health nurse contributed in advance by telephone. Ms Latham would not attend but said she would continue to refuse to eat, but would drink water with her medication. The staff assessed that Ms Latham’s risk of suicide and self-harm remained high and kept her observations at twice an hour. Ms Latham accepted

some emergency phone credit. Later that afternoon, she made a cup of tea, and collected her evening meal and a breakfast pack for the next day. The officer noted that she appeared in better spirits.

59. On 14 November, Ms Latham left her cell to spend some time outside in the open air and collected her lunch. She made further enquiries about her make-up brushes and said she also expected to receive a wig she had ordered. She later collected her evening meal, was polite and apologised to staff for her recent behaviour.
60. On 16 November, the psychiatrist reviewed Ms Latham, with the mental health nurse present. Ms Latham said she had violent thoughts, could not cope with stress, did not trust staff and did not get on with the prison psychologist. She asked the psychiatrist to refer her to a psychiatric hospital, but he did not consider it appropriate. Ms Latham said she was coping better.
61. A SO and the mental health nurse held an ACCT case review that day. Ms Latham did not take part, although she had told staff she did not feel suicidal. They decided that the frequency of observations should be reduced to three conversations a day, one observation over the lunch period and five observations at night. When they told Ms Latham later, she was content with that. A SO told Ms Latham that the risk assessment meeting in two days' time would consider whether she could have the make-up brushes. (However, the meeting was cancelled.)
62. Over the following days, staff noted that Ms Latham's behaviour had improved. They recorded that she was calmer, collected her meals and interacted with staff.
63. On 19 November, a SO and the mental health nurse held another ACCT case review. The SO noted that Ms Latham was upbeat and jovial. She still wanted her make-up brushes and also spoke of future plans. The case review assessed Ms Latham's risk of suicide and self-harm as low and they ended ACCT monitoring. The SO noted in the wing observation book that they would issue Ms Latham with make-up brushes, as with a razor. This meant that she would need to show them to officers before they unlocked her cell.
64. On 21 November, Officer A noted in the CSC report that Ms Latham remained on a four-officer unlock and that she could have her make-up brushes (although the risk assessment meeting had not met yet). Ms Latham was pleased and the officer told Ms Latham that staff would be supportive.
65. On 23 November, Ms Latham declined to see the mental health nurse for a mental health appointment. She said she had constipation and stomach cramps due to her medication. A GP saw her the next day and prescribed dihydrocodeine to relieve her pain.

### **Wednesday 25 November**

66. On 25 November, staff noted at a dynamic risk assessment meeting that Ms Latham was settled and no longer needed four officers present to unlock her. They decided that, once the security department had photographed them, Ms Latham could have her make-up brushes. Officer B told the investigator that Ms Latham was happy about this decision and should have got the brushes the next

day. However, no one took the brushes to the security department to be photographed that afternoon as planned. An officer spoke to Ms Latham that evening and said she appeared elated.

### Thursday 26 November

67. On 26 November, an officer who worked in the security department told Officer B that the security manager wanted to check the make-up brushes before allowing Ms Latham to have them. When her cell was unlocked that morning, Ms Latham asked Officer B if there was any further news about her brushes. He told her that the security department needed to photograph them before allowing her to have them. He noted that Ms Latham was irritated by the news, became abusive and accused staff of changing their minds. Shortly afterwards, Ms Latham asked for a razor. He told her that he would need to get another member of staff to help and she then threatened to kill him in a very violent manner. Because of this, the requirement for four officers to be present when Ms Latham's cell was unlocked was reinstated.
68. After Ms Latham made further threats to kill staff that morning, she asked them to remove the television from her cell, as she said she would not need it for what she was going to do that afternoon. They took the television out of her cell before lunch, when Ms Latham was taken to a meeting with the mental health nurse.
69. The mental health nurse noted that Ms Latham was agitated and continued to threaten staff. She said that she was upset that officers had changed their minds about the make-up brushes. Ms Latham acknowledged that the further requirement for the brushes to be photographed and the security manager to approve them was not the fault of CSC officers, but said they should not have told her she could have them until this had been finally agreed. She said that if she was provoked, she would cut her throat. Ms Latham said that she wanted to be left alone and did not need to be monitored as a risk of suicide and self-harm. However, the nurse re-opened the ACCT procedures.
70. After lunch, staff held another ACCT case review. The mental health nurse noted that Ms Latham had threatened to kill staff and said that she did not want to be monitored. Ms Latham said that if they did monitor her, she would cut her throat. The staff assessed her as at raised risk of suicide and self-harm and told her they had no alternative but to begin ACCT procedures. The SO told the investigator that Ms Latham was highly charged and emotional during the review. When Ms Latham left, they agreed that Ms Latham would find it provocative and intrusive to be constantly observed, or checked every five minutes. They thought that this might increase her risk still further and therefore agreed to observe her hourly, with five observations during the night. They arranged to hold another ACCT case the next day. They did not set any additional caremap actions or discuss her lack of access to make-up brushes, which had triggered the original ACCT procedures and had been set as an initial caremap action.
71. Afterwards, the mental health nurse went to see Ms Latham in her cell. Ms Latham told her to fuck off and turned off the cell light. When Officer C checked her at 2.56pm, she said, "Don't worry, I'm alive now. Bugger off and retreat back down them stairs".

72. Ms Latham told Officer A that she was at breaking point and that someone was going to get it. She told Ms Latham that everyone had choices and she should think about the bigger picture. Ms Latham told her that it had gone too far, and referred to two officers as targets for her threats.
73. At 3.15pm, Ms Latham was given her medication. At 3.55pm, officers let her out of her cell to make a telephone call and she swore at them. (Ms Latham was out of her cell for about two minutes, but there is no record that she made a call.) At 4.30pm, officers unlocked Ms Latham's cell and took her to collect her meal but she would not speak to them. At 5.05pm, Officer C noted that she was watching television. (It is not clear from the records when Ms Latham's television had been returned to her.) The SO told the investigator that most of the CSC's managers left the prison between 5.00pm and 5.30pm, leaving the duty governor and him responsible for the unit.
74. At around 6.00pm, Officer A spoke to Ms Latham. She noted in the ACCT record that Ms Latham had said she was not bluffing, but said no more. Just before 7.00pm, Ms Latham said she had a plan she would carry out. She said that she was at breaking point and somebody would "get it", unless Woodhill referred her to a psychiatric hospital. Ms Latham said that the outcome of her actions would get her transferred. She told Ms Latham that she could choose to work with the officers, but Ms Latham said it had gone too far. She said she thought Ms Latham was planning to harm staff.
75. At 7.11pm, the duty governor that day visited the CSC. He had had no previous contact with Ms Latham. He said the SO told him that Ms Latham had threatened staff because she had not been given her make-up brushes and they had started ACCT procedures. He went back to the main prison and the SO and Officer C left the prison around 7.45pm.
76. At 7.55pm, Officer A checked Ms Latham, who had blocked the observation panel with a cloth. She said that she could see through the gap in the doorframe that Ms Latham had moved some of the cell furniture behind the door to make a barricade. She could not see Ms Latham but asked her what she was doing. Ms Latham said that if officers came into her cell, she would "brain one" to get a transfer.
77. At around 8.00pm, Officer A phoned a custodial manager, who was the evening duty manager, and told him what was happening. She said he said he would pass this on to the night manager, as there were no managers in the CSC at the time.
78. There is some confusion about what information managers had after that. The evening duty manager told the investigator that before he left the prison at around 8.30pm, Officer A had not told him that Ms Latham had built a barricade. (Records show that he left the prison at 8.58pm.) He said the night manager on 26/27 November and Officer the night manager's deputy were with him when he spoke to Officer A.
79. The evening duty manager said he had told the night manager to speak to the duty governor if he needed to go into Ms Latham's cell, as she was on a "four-officer unlock". The night manager said he did not recall this conversation. The

- evening duty manager said that the night manager told him he did not need extra help and could deal with the situation. The night manager said he could not recall speaking to the evening duty manager about the situation. However, the duty governor said that the evening duty manager had told him that Ms Latham had covered the observation panel in her cell door.
80. The night manager said that he had arrived at the prison at around 8.15pm and the evening duty manager had told him what was happening in the prison as a handover. He could not remember whether the evening duty manager had discussed Ms Latham or the situation in the CSC but he was confident that he would have done. The evening duty manager said he had told the night manager that Ms Latham had covered her cell observation panel. The night manager said that the evening duty manager had told him that Ms Latham had barricaded her cell. The duty governor said that he knew that Ms Latham's observation panel on her door was covered but not that she had barricaded her cell. The duty governor said the night manager had told him that he would speak to Ms Latham and update him on the situation.
81. At around 8.15pm, Officer D arrived in the CSC to begin a night duty. Two officers handed over to him and told him that Ms Latham had barricaded her cell and covered the observation panel. Over the next hour, he and two other officers, one of whom was working in the other part of the CSC that night, tried to speak to Ms Latham. Officer D said he asked her to unblock the observation panel but she threatened she would attack officers with weapons she had made and that she would harm herself if they opened her cell door. At 8.45pm, he noted that Ms Latham had unblocked the observation panel for a while and had made a small cut to her wrist. At around the same time, he phoned the night manager and said that Ms Latham had barricaded her cell. The night manager told him to monitor the situation and that he would come to the CSC to try to resolve the matter.
82. The two day officers left at around 8.50pm, after Officer D said that he was okay on his own. Officer A said that before she left, she had told the evening duty manager that Ms Latham had broken either her sink or television. She said that he told her he would pass the information on. He said he could not recall this and believed that he had left the prison by this time. (In fact, as noted earlier, he was still in the prison and did not leave until 8.58pm.) On their way out of the prison, the officers met the night manager and his deputy and told them that Ms Latham had barricaded her cell and blocked her observation panel.
83. At 9.03pm, the night manager and his deputy arrived in the CSC. Officer D spoke to them about the situation before the three of them and Officer E went to Ms Latham's cell. The night manager asked Ms Latham to uncover the observation panel, which she did. He said there were bed sheets hanging from the ceiling and walls and she had barricaded the cell door. He asked Ms Latham if she intended to harm herself. She said that she already had and was not afraid to do it again. She repeated threats to assault Officer B. He told Ms Latham that there were plans to resolve her issues the next day and staff would keep her as safe as possible. He told her he would check on her during the night. He told Officer D to check Ms Latham regularly and contact him if her behaviour changed. He left the CSC at 9.40pm.

84. The deputy night manager told the investigator that they discussed increasing Ms Latham's frequency of observations, but he could not recall what the night manager decided. He said that because there was good communication with Ms Latham and they needed a number of officers to go into her cell, the night manager had decided that they should not force entry into her cell at this point.
85. At around 9.45pm, Ms Latham told Officer D that she had been planning her actions since lunchtime. She continued to threaten to injure Officer B, and said she had weapons in her cell. Ms Latham said she had broken her television by accident and showed him a small cut on her wrist.
86. At around this time the night manager said he telephoned the duty governor as he had promised to update him after he had seen Ms Latham. He told him that Ms Latham had barricaded her door but he did not intend to unlock the cell. He said the duty governor was content with this decision and asked him to contact him again if he needed further help. Although she had been assessed earlier as at raised risk of suicide and self-harm, and had cut herself shortly before, the night manager told the investigator that he did not consider that Ms Latham was at real risk at that time.
87. The duty governor said the night manager told him that he had spoken to Ms Latham and persuaded her to remove the cloth from the observation panel. He said he had asked him if staff needed to go into Ms Latham's cell before the day staff went off duty. He said the night manager had told him that he did not think this was a good idea as Ms Latham had removed the material she using to block her observation panel and officers had built a rapport with her. He said the night manager had told him that if officers went into the cell in personal protective equipment (PPE), this could upset Ms Latham and make the situation worse. He said he checked with the night manager that he was sure that staff did not need to go into the cell to remove the material that she was using to block her observation panel, but the night manager confirmed his position. He said he had agreed with the night manager that they should increase Ms Latham's observations to three an hour. (There is no evidence that the night manager increased Ms Latham's observations until later that night, and when he did, he increased them to two an hour.) The duty governor left the prison at around 10.00pm. He said he was not aware that Ms Latham had built a barricade in her cell. He said that given the information he had, he believed the action taken was appropriate.
88. The night manager told the investigator that he had not reviewed the ACCT record, as he believed Ms Latham was doing everything asked of her, except removing the barricade. He said he did not consider increasing the observations, as he was not concerned about her safety at that time.
89. Between 10.00pm and 10.30pm, Officer D checked Ms Latham three times. At 10.25pm, he noted in the observation book that he had tried to reason with her and calm the situation. He said that she had removed the cloth from the observation panel when he talked to her, but put it back when he left. Ms Latham told him that she had spread butter on the floor of the cell and that she had some glass, which she would use on either herself or an officer.

90. Officer D went back to her cell at 10.36pm and again at 11.02pm, with Officer E, when they talked to Ms Latham for about 15 minutes. Ms Latham asked Officer D for some tobacco but he said he could not give her any, and told her to speak to the night manager about this when he next visited. He told Ms Latham that there were issues to resolve, such as her threats to attack staff and barricading her cell. Ms Latham told him that anything “could be compromised”. He said he interpreted this to mean that Ms Latham would dismantle the barricade in return for tobacco. Ms Latham said that she had built a good barricade and he said he had warned her that if she harmed herself, it would be difficult for staff to get into her cell to help her.
91. At around 11.45pm, Officer D asked the night manager when he would next come to the CSC, as Ms Latham wanted to speak to him. The night manager said he would be there as soon as possible.
92. At 11.53pm, Ms Latham rang her cell bell and asked to speak to the night manager. Officer D told her that Mr Brady would be there soon. He noted that this had not been good enough for Ms Latham and phoned the night manager again and asked him to visit the unit. (The night manager told the investigator that Officer D had called him a number of times that night.) Officer D again told Ms Latham that the night manager would see her soon.

#### **Friday 27 November**

93. At 12.30am on 27 November, the night manager went to Ms Latham’s cell with Officer D and his deputy. Ms Latham told him she felt stressed and needed to smoke. She showed him a large cut she had made to her left forearm. He said he was shocked by the size of the cut.
94. The emergency response nurse arrived at 12.40am. Ms Latham refused to show the nurse her injury and the nurse said the night manager told her that because Ms Latham had threatened staff, he could not unlock her for treatment.
95. The night manager asked Ms Latham how they could resolve the situation and she asked for tobacco. He told her that he was not able to give her tobacco, but they would sort out her issues the next day. He said he was not willing to give Ms Latham tobacco because she had threatened to assault staff and because she had refused treatment from the nurse (although the nurse had no access to her.) He asked Ms Latham to remove the barricade and she refused again. He then told Ms Latham that he had to leave the unit. Officer D said that the night manager did not allow Ms Latham to have tobacco because she had been manipulative and made threats and because of the logistics of opening the cell during the night when four officers were supposed to be present for Ms Latham to be unlocked.
96. Before he left the unit, the night manager, his deputy and Officer D held an ACCT case review. The night manager noted that Ms Latham had cut her arm and barricaded her cell. They assessed that Ms Latham’s risk was still raised and increased her observations from five during the night, to two an hour. He recorded that he had reviewed the caremap, but he did not add any new actions. Before leaving the unit, he told Officer D to let him know if the situation changed.

97. The night manager told the investigator that he was uncomfortable about opening a cell in the CSC at night, and jeopardising the safety of staff and the security of the prison, because of a prisoner who had made threats to assault staff and had weapons. The deputy night manager said that they did not discuss going into the cell, but it would have been extremely dangerous, because of the situation and the staffing levels at night.
98. The front cover of the ACCT record indicated that on 27 November, Ms Latham's observations were increased to two an hour. It appears that, after the case review at 12.52am, the night manager had written three an hour on the front cover, but Officer D checked this with him and confirmed that they had decided there should be two. The officer changed the front cover to reflect this. The night manager had noted in the ACCT record at 12.52am that he had raised the interactions to two an hour because Ms Latham kept blocking her observation panel.
99. At 1.00am, Officer D checked Ms Latham and she asked for tobacco again when he asked her how they could resolve things. At 1.30am, she was still preoccupied about not having any tobacco and he told her she knew she could not have any. She then said that she would not respond to further checks. He said he told her he did not want her to harm herself and she should ring the cell bell if she needed him. Ms Latham covered her observation panel again.
100. At 2.00am, Officer D tried to get a response from Ms Latham. She responded eventually and demanded to see the night manager. He noted in the ACCT record that he had spoken to the night manager, who said he was not prepared to come to the CSC for a third time, give Ms Latham tobacco or open her cell.
101. At 2.23am, Ms Latham rang her cell bell and Officer D spent ten minutes talking to her. She said she was anxious that officers would force entry to her cell. He told her that this would not happen. Ms Latham asked why the power in her cell had been cut off. He told her it had not been cut off, but she did not accept this. Ms Latham again threatened to harm herself and said he "would be fucked" if he did not do something about it. He told Ms Latham that the night manager would not allow her to be given any tobacco. He said he found it difficult to reason with Ms Latham and had asked the night manager to come to talk to her again. Around 2.45am, the night manager told him to monitor the situation. The officer noted in the ACCT record that Ms Latham was not happy that she could not speak to the night manager.
102. At 3.00am, Ms Latham acknowledged Officer D when he checked her and he noted that her cell light was on. When he checked her at 3.30am, Ms Latham told him to fuck off. At 4.00am, she said that she was okay and asked the time.
103. At 4.30am, Officer D checked Ms Latham again but was unable to get a response and radioed for help. The night manager told him to keep trying and that he and other staff would come to the CSC soon. At 4.35am, Officer D, joined by Officer E, went back to Ms Latham's cell, but could still not get her to respond.
104. The night manager radioed his deputy and told him to go straight to the CSC. The deputy arrived at 4.40am. He was also unable to get Ms Latham to respond

and at 4.43am, phoned the night manager to update him. The night manager said he would get the equipment to open barricaded cells from the operations room and join them soon.

105. At 4.47am, the deputy night manager and Officer E went back to the cell. At 4.54am, Officer D went to the wing interview room and updated the night manager. The deputy night manager joined him and at 4.57am, Officer E, also went to the interview room, which left no one outside Ms Latham's cell. The deputy night manager said that they discussed whether they should go into the cell and how they would do it, balancing their safety against Ms Latham's interests. They decided not to go in immediately. At 5.01am, the officers went back to Ms Latham's cell. Officer D knocked and called to Ms Latham several times, but got no response.
106. The night manager decided that they needed to go into Ms Latham's cell. At around 5.00am, he asked a SO in the control room to contact the duty governor at home to let him know that they intended to open the cell.
107. The duty manager said the SO had told him that the staff could not get a response from Ms Latham and needed his permission to go into Ms Latham's cell, which he gave. He said he was unaware at that time that Ms Latham had barricaded her cell. The night manager said he had asked the SO to contact the duty governor to keep him updated about what was happening. He said he would not have waited for the duty governor's permission to go into the cell, as he had that authority. In a subsequent telephone call, the night manager said the duty governor told him that he trusted his judgement and he should do what he felt was necessary and appropriate. He said he found it strange that the duty governor had said he had not known about the barricade at this time, as he was sure that he had told him.
108. At 5.06am, Officer F arrived and joined the deputy night manager and Officer D and E in the interview room. At 5.09am, the night manager radioed the emergency response nurse and told her to go to the CSC. The nurse said she took her emergency bag, containing basic first aid equipment. There was a defibrillator and oxygen in the CSC.
109. At 5.12am, Officer D went back to the cell. At 5.16am, the night manager arrived in the unit and joined the officers in the interview room. Officer D came back to the interview room, leaving no one at Ms Latham's cell.
110. The deputy night manager and Officer D briefed the night manager. The night manager told the investigator that because Ms Latham was on a four officer unlock, the protocol was that two teams of staff wearing personal protective equipment (PPE) had to deal with the incident. Because of the urgency of the situation, the night manager agreed with the officers that they would go into the cell without PPE, but would use a full body length shield as protection. At 5.19am, the staff left the interview room and went back to Ms Latham's cell. The deputy night manager went to get the shield and returned at 5.23am.
111. The officers confirmed that they were prepared to go into the cell without personal protection equipment and at 5.26am, the night manager used the tools he had brought to open the cell door outwards. The deputy night manager shone

a torch over the top of the barricade and saw Ms Latham hanging from the window at the back of the cell.

112. The deputy night manager and the officers tried to dislodge the barricade with the shield. The night manager said it was extremely difficult to get into the cell. The officers were able to remove a mattress, but some furniture units were tightly wedged in the doorway. Officer F jumped over the remainder of the barricade and went into the cell. The night manager radioed the control room, called an emergency code blue and asked them to call an ambulance immediately.
113. Officer F supported Ms Latham's body and then cut the ligature, made from a cord-like material, and laid her on the floor. He checked for signs of life but found none. He said Ms Latham was cold and limp, with swollen eyes. The other officers went into the cell when he fully removed the barricade, at around 5.28am. He immediately started chest compressions until the emergency response nurse arrived around 30 seconds later and handed over to her. He said the nurse left the cell, but he could not recall anyone carrying out chest compressions at that time.
114. The nurse said that when she went into the cell, she checked for signs of life, and then went to bring a defibrillator and oxygen from the wing office. She attached the defibrillator, which found no shockable heart rhythm, and gave Ms Latham oxygen through a facemask. She said Ms Latham was cold and clammy, with fixed pupils. She did not begin cardiac pulmonary resuscitation (CPR), but said she asked Officer F to do this. The night manager told the investigator that Officer F then continued with CPR, although the officer said he had not.
115. The nurse said that in her opinion Ms Latham was dead, but she continued to supervise CPR until paramedics arrived. At 5.36am, paramedics arrived and continued emergency treatment. Ms Latham did not respond and at 6.20am, paramedics recorded that she had died.
116. The prisoner in the cell next door to Ms Latham said he had no contact with her, heard nothing during the night and only became aware of the incident when officers went into the cell.

### **Contact with Ms Latham's family**

117. At 9.25am, the duty governor and the safer prisons manager asked another manager to act as the prison's family liaison officer.
118. The family liaison officer was unable to contact Ms Latham's father or brother, but Ms Latham's brother called her back after noticing a missed call and she told him that Ms Latham had died. He agreed to let his father know. There had already been a delay, as there had been no trained family liaison officer available during the night. The family liaison officer noted that due to the distance to Manchester and the likely media coverage, she did not make a personal visit to Ms Latham's family to tell them of her death. She spoke to Ms Latham's father that morning to offer her condolences and support. The prison offered to contribute to the funeral expenses in line with national instructions.

### **Support for prisoners and staff**

119. The duty governor debriefed the staff involved in the emergency response and offered support. The prison notified other prisoners of Ms Latham's death and offered support. Officers reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Ms Latham's death.

### **Post-mortem report**

120. The results of the post-mortem examination gave the cause of death as hanging. Toxicology tests showed that Ms Latham had no illicit substances in her bloodstream at the time she died. Tests detected therapeutic levels of anti-depressants and above therapeutic levels of paracetamol. However, the level of paracetamol was below the level at which toxic effects would be expected.

## Findings

### Support for Ms Latham as a transgender prisoner at Woodhill

121. Ms Latham had begun to live as a transgender woman in August 2015. We had no significant concerns about the way Woodhill treated or supported her as a transgender prisoner, although we noted a number of entries in her records continued to refer to her as a man, after the prison had recognised her decision to live as a woman. It is unfortunate that delays and problems with issuing make-up brushes seemed to cause Ms Latham such distress but, while this could have been managed better, we consider that this was related to general security restrictions in the CSC related to risk, rather than any intention to prevent her having access to items to help her live as a woman. We are satisfied that Woodhill appropriately supported Ms Latham's decision to live as a woman and followed the guidelines in Prison Service Instruction 7/2011, about transgender prisoners.

### Response to the barricade

122. Prison Service Instruction (PSI) 09/2014 about managing incidents in prison says that (unless there are particular exceptions) prisons must have contingency plans to deal with risks such as barricades, deliberate self-harm and deliberate damage to prison property, including at night. Woodhill's local instructions for managing barricades say that managers should report to the scene, take command, establish the reason for the barricade, obtain cell door release equipment, and ensure that healthcare staff are ready to deal with potential injuries to staff or prisoners. Local instructions say that if prisoners cover door observation panels at night, staff should inform the night orderly officer (night manager) immediately and staff should be sent to the cell.
123. The staff did not follow the national or local instructions to manage Ms Latham's situation until it was too late. There were conflicting accounts from officers and managers about the handover period on the evening of 26 November, which meant that we could not establish for certain what information was relayed to night staff, by whom and when. However, it is clear from the evidence that Ms Latham had blocked her observation panel and barricaded her cell at around 8.00pm and that she had self-harmed and damaged property in the cell by 9.00pm.
124. The evening orderly officer (duty manager) and duty governor, who was the duty governor at the time Ms Latham first barricaded, said they were unaware of the barricade. The evening duty manager left the prison shortly before 9.00pm and the duty governor left at about 10.00pm. It seems strange that staff would not have given them this information, but the night manager was aware that Ms Latham has barricaded her cell not long after he came on duty. It is possible that it was the staff who were leaving the CSC who told him this rather than either of the managers. He went to Ms Latham's cell just after 9.00pm and reported to the duty governor at about 9.45pm, shortly before the duty governor left the prison. The duty governor could not recall this, but it seems likely that the night manager would have mentioned that Ms Latham had barricaded her cell. It is also difficult to understand why the duty manager would have suggested sending in staff to

remove the material that Ms Latham was using to cover the observation panel when she could have immediately replaced it with something else. Whatever, the sequence of events and passing on of information, there were undoubtedly communication failures.

125. The night manager faced a difficult situation on 26 November when he arrived on shift and had to deal with a CSC prisoner at risk of suicide and self-harm, who required four officers to unlock her and had blocked her observation panel and barricaded her cell. He was a newly promoted and inexperienced night manager, with no training or experience of dealing with prisoners in the CSC, the most dangerous and difficult to manage prisoners in the system. We accept his assessment at the beginning of his shift was that the situation was under control, and that Ms Latham was interacting with staff, who were doing what they could to look after her. We understand that he had not wanted to antagonise Ms Latham by going into her cell by force and had wanted to resolve the matter peacefully. Fundamentally, he had not wanted to jeopardise the safety of staff and the security of the prison.
126. We recognise that prison staff have to make difficult judgements about such situations based on their operational experience and sometimes these judgements might not be correct. However, the situation on the night of 26/27 November was not static. We would have expected staff to review the situation as it evolved, particularly in light of the priority the national instruction (PSI 64/2011) and local instruction (2.198) places on the preservation of life when managing prisoners at risk.
127. Ms Latham cut her wrist some time in the evening of Friday 26 November and then made a significantly more serious cut to her arm, which she showed the night manager at 12.30am. He had noted that Ms Latham had sheets hanging from the walls and ceiling and Ms Latham had said she had two large pieces of glass, which she would use either to injure herself or staff. Despite this, it was nearly 5.30am the next morning, before staff went into Ms Latham's cell. No one made any plans to go into the cell until after she stopped responding, which was too late.
128. The delay in going into the cell from the time Ms Latham did not respond at 4.30am was particularly indefensible. Ms Latham had been identified as at raised risk of suicide and self-harm, had constantly covered her cell observation panel and had continued to threaten to harm herself. We consider that the staff should have made plans to enter her cell at an opportune and safe moment much earlier. The tools to open the cell door should have been brought to the CSC as soon as she had barricaded the cell and a member of healthcare staff should have been ready, in line with the local instructions. We make the following recommendation:

**The Governor should ensure that staff follow local instructions to manage situations when prisoners barricade their cells and, take all reasonable steps to gain access to a barricaded cell quickly, particularly when the prisoner is assessed as at risk of suicide and self-harm.**

## Assessment and Management of risk of suicide and self-harm

129. Ms Latham had a significant history of serious self-harm and staff had monitored her under ACCT procedures many times, including at the time of her death. We had some concerns about how effectively the procedures operated to protect her.
130. We do not consider that the level of observations on the night of 26/27 November, reflected Ms Latham's risk of suicide or self-harm. Shortly after Ms Latham first cut herself on the evening of 26 November, she told the staff that she intended to harm herself again, and had the means to do this. She showed Officer D cuts at 8.45pm and again at 9.45pm. It is not clear whether these were the same cuts. No one formally reassessed her risk of suicide and self-harm at the time. The duty governor believed they had agreed to raise observations to three an hour but there is no record of this.
131. After Ms Latham seriously self-harmed later, the night manager held an ACCT case review with the officers who were present. They assessed Ms Latham as at raised risk and set observations at twice an hour. We believe this was an underestimation of her risk and the level of observations was too low. As the seriousness of Ms Latham's self-harm had escalated and she had threatened to continue to harm herself, we consider that staff should have assessed her risk as high and monitored her much more frequently, particularly because she had barricaded her cell and often covered her observation panel. The possibility of constant supervision should have been considered. Prison Service Instruction 07/2011, which covers transgender prisoners, indicates that transgender prisoners should be considered a high-risk group for suicide. There is no evidence that any of the staff took this into account.
132. Prison Service Instruction PSI 64/2011, which covers ACCT procedures, says that staff must follow the level of observations set on the ACCT record and make those observations at unpredictable intervals. From 12.30am to 4.30am on 27 November, all the checks were recorded either on the hour or half-past the hour.
133. PSI 64/2011 says that caremaps must reflect a prisoner's needs, level of risk and the triggers of their distress. Caremaps should address issues identified in the ACCT assessment interview. They should say who is responsible for completing the action within a specified timeframe. ACCT plans should not be closed until caremap actions are completed.
134. On 12 November, the staff had identified the lack of access to make-up brushes as the only issue to be addressed in her caremap. There is no clear evidence that subsequent case reviews referred to this and when staff ended ACCT procedures on 19 November, Ms Latham had still not obtained the make-up brushes. While obtaining make-up brushes might have seemed relatively trivial, this had been identified as the reason for her self-harm. No one seemed to have recognised the importance of the issue to Ms Latham, a personality disordered person living in a very restrictive environment and embarking on a major change in her personal identity. We consider that someone should have taken active steps to resolve this more quickly and staff should not have closed the ACCT until this caremap action had been completed. When ACCT monitoring began

again on 26 November, no one at the review referred to this outstanding caremap action.

135. We make the following recommendation:

**The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:**

- **A trained ACCT assessor should complete an assessment within 24 hours of the ACCT being opened, using all available information if the prisoner refuses to engage.**
- **ACCT case reviews should assess the level of risk taking into account all risk factors.**
- **Levels of observations should reflect the risk and staff should carry out and record all required observations at unpredictable intervals.**
- **Case managers should review progress against caremaps at each review and not close ACCT plans until caremap actions have been completed.**

### Close Supervision Centre Training

136. The National Offender Management Service's operating manual for Close Supervision Centres says that staff working in CSCs must receive nationally approved training. Many prison staff we interviewed had not completed this training, including managers responsible for the unit during the night. The duty governor had not had CSC training but had previous experience of working in the unit. The night manager and a SO had no experience of the CSC and had not had the CSC training. The night manager said he had only completed one set of night duties as a manager before Ms Latham's death, and was apprehensive about having to manage the unfolding incident in the CSC when he came on duty.

137. CSCs are an extreme form of custody and the prisoners held in them are assessed as dangerous and difficult to manage. We consider that staff and managers working in CSCs or responsible for them at night, should have the necessary training and skills to deal with confidence with any incidents that arise in the CSC. We make the following recommendation:

**The Governor should ensure that all staff who work in the CSC, have appropriate training and that all managers who have responsibility for the CSC at night and other times are appropriately trained and equipped to manage incidents in the CSC.**

### Emergency response and resuscitation

138. There were conflicting accounts of what happened after officers and the nurse went into Ms Latham's cell. Officer F went into the cell first and started cardiopulmonary resuscitation (CPR), but said he stopped soon after the nurse arrived and handed over to her as a medical professional. The night manager said that Officer F continued CPR for several minutes. The emergency response nurse said she did not give chest compressions, but left the officer giving chest compressions while she went to get the defibrillator and oxygen. She said she then supervised officers giving chest compressions until paramedics arrived and

took over emergency treatment. Because of the differing accounts, we cannot be sure that CPR was administered appropriately.

139. We are concerned that the nurse had to leave the cell to get a defibrillator and oxygen. While these were nearby in the CSC, we would have expected the staff to have had emergency equipment waiting outside the cell before they went in. In addition, when the night manager radioed a code blue medical emergency at 5.28am, someone should have brought appropriate emergency equipment including a defibrillator. When the nurse found that she needed additional equipment it would have been better to have asked officers to bring it, rather than leaving the cell.
140. PSI 3/2013, about medical emergency codes, requires all prisons to have a medical emergency response code protocol, based on the instruction, which ensures that staff called to the scene bring relevant equipment. It states that all staff must be aware of their responsibilities in a medical emergency, but it does not appear that staff were clear about their roles during the emergency response. We would have expected the nurse to make sure the staff administered CPR appropriately until paramedics arrived or to have done so herself.
141. It does not appear that any of the deficiencies in the emergency response affected the outcome for Ms Latham, as it seems likely that she was already dead by the time staff got into the cell. However, in future emergencies, any delay could be crucial. It is important that staff clearly understand their responsibilities in emergencies. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities in a medical emergency, including bringing relevant equipment immediately. Unless there are clear signs of death, staff should administer and continue basic life support until paramedics arrive.**

### Clinical care

142. The clinical reviewer concluded that the general standard of health care Ms Latham received at Woodhill was comparable to the care she would have received in the community. He did not identify any shortfalls in the care and service given to Ms Latham. He found that the mental health team supported Ms Latham and developed a crisis plan with her. Their records were comprehensive and they discussed her care at multidisciplinary meetings. Healthcare staff regularly assessed and reviewed her.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations