

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Lane a prisoner at HMP Guys Marsh on 24 March 2016

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



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

Mr Lane was found hanged in his cell at HMP Guys Marsh on 24 March 2016. He was 40 years old. I offer my condolences to Mr Lane's family and friends.

I am concerned that prison staff appear to have taken insufficient account of Mr Lane's risk factors for suicide and self-harm, including a previous attempt to take his life and thoughts of doing so again, substance misuse, bullying and debt. Although Mr Lane told staff he was being bullied, little was done to support him or investigate the perpetrators. There were also deficiencies on the night of Mr Lane's death. In particular, staff did not respond quickly or effectively when he covered his observation panel, despite having earlier told them he was being bullied. I drew a similar issue to the Governor's attention in 2015 following a death and I am very disappointed to have to do so again.

More generally, I share HM Inspectorate's concern about the availability of illicit substances, particularly new psychoactive substances, at Guys Marsh. The ease with which Mr Lane appears to have been able to obtain such drugs, including on the drug treatment and recovery wing, is very troubling and must be addressed.

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

November 2016

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	10

Summary

Events

1. Mr Simon Lane was remanded to HMP Bullingdon in April 2015. He was later sentenced to three years and nine months in prison. He transferred to Guys Marsh on 10 November.
2. In early 2016, prison officers found Mr Lane under the apparent influence of new psychoactive substances on several occasions, and referred him to the substance misuse team. Prisoners who knew Mr Lane said he accumulated debts because of his drug use. On 18 March, Mr Lane told a substance misuse recovery worker that other prisoners had threatened him and he wanted to move to another unit. He spoke of a previous attempt to take his life and said that these feelings had returned. The substance misuse recovery worker referred Mr Lane to the prison's mental health team and helped arrange a move to another unit, but did not begin Prison Service suicide and self-harm prevention procedures, known as ACCT, as Mr Lane presented well at the time. No one initiated local violence reduction procedures.
3. On the night of 23-24 March, Mr Lane called the night patrol officer to his cell and said other prisoners were bullying him and he needed to move to another unit. The night patrol officer told the officer who relieved him in the morning. At around 7.30am on 24 March, the officer found that Mr Lane had blocked his observation panel. He did not take any action. At around 7.50am, another officer began unlocking cells on the unit and found Mr Lane hanging from a ligature in his cell. Mr Lane had barricaded the door, and this delayed prison staff entering the cell and starting cardiopulmonary resuscitation. Paramedics arrived but recorded that Mr Lane had died.

Findings

4. Mr Lane had a number of risk factors for suicide and self-harm, which he discussed when he met the substance misuse recovery worker on 18 March. She was not trained in ACCT procedures as national policy requires. We are concerned that she based her decision not to start ACCT procedures on Mr Lane's presentation, rather than having considered his known risk factors. We found that prison staff did not start local violence reduction procedures as they should have done, and most prison staff were unaware that Mr Lane was potentially at risk of violence. Mr Lane frequently used new psychoactive substances including, reportedly, following his transfer to the drug treatment and recovery unit and on the night before he died. Like HM Inspectorate of Prisons, we are concerned about the apparent levels of use of these substances in the prison.
5. We found that the night patrol officer could have done more when Mr Lane spoke to him on the night of his death. The officer's response when he found Mr Lane's observation panel covered the next morning was very poor and not in line with local guidelines.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage and support prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - All staff record, share and consider all relevant information about risk and open ACCT procedures when indicated.
 - All staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011.
- The Governor should ensure that all information about bullying, intimidation and the use of drugs is fully coordinated and investigated; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situations.
- The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that staff are vigilant for signs of its use and are briefed about how to respond when a prisoner appears to be under the influence of such substances.
- The Governor should ensure that night patrol officers inform the night orderly officer whenever a prisoner indicates they are at risk of bullying or violence, that they consider all relevant information about risk and open ACCT procedures when indicated.
- The Governor should ensure that prison staff respond to blocked observation panels in line with local instructions, including that they enter cells as quickly as possible if there is information that the prisoner may be at risk.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Guys Marsh, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
7. The investigator visited Guys Marsh on 30 March. He obtained copies of relevant extracts from Mr Lane's prison and medical records, and interviewed two prisoners who knew Mr Lane.
8. The investigator interviewed nine members of staff at Guys Marsh in May and June.
9. NHS England commissioned a clinical reviewer to review Mr Lane's clinical care at the prison. He joined the investigator for interviews with prison and healthcare staff.
10. We informed HM Coroner for Dorset of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Lane's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Lane's father asked whether his son used drugs in prison, whether he was in debt for drugs, and whether this was a contributory factor to his death.
12. Mr Lane's family received a copy of the initial report and indicated they were satisfied with the findings.

Background Information

HMP Guys Marsh

13. HMP Guys Marsh holds up to 579 men who are usually nearing the end of their sentence. Dorset University Healthcare Foundation Trust provides primary and secondary general and mental healthcare, and commissions another agency, EDP, for substance misuse services.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Guys Marsh was in November 2014. Inspectors were very critical and described the prison as in crisis. They found that levels of violence were three times higher than at the last inspection and many prisoners told inspectors that they did not feel safe. Violence was driven by the supply of drugs, particularly synthetic cannabinoids (also known as new psychoactive substances). Inspectors found that violence was particularly prevalent on Saxon Unit, which was designated as a drug treatment wing but which also held prisoners for their own protection, often because of drug debts.
15. Inspectors also found that incidents of self-harm were high, but there was a focus on providing good care for prisoners at risk of suicide and self-harm.

Independent Monitoring Board

16. 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 November 2015, the IMB reported serious concerns about the availability of new psychoactive substances at Guys Marsh, that there was a spiral of debt associated with these drugs, and that levels of violence were unacceptably high. They also said that prison staff needed additional training to help them identify when to begin ACCT procedures.

Previous deaths at HMP Guys Marsh

17. Mr Lane is the fifth prisoner to die at Guys Marsh since January 2015, and the third to take his own life. In our investigation into the death of a man in April 2015, we found that prison staff responded too slowly when the man blocked his observation panel on the night of his death.

Assessment, Care in Custody and Teamwork

18. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances

19. New psychoactive substances are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many new psychoactive substances contain synthetic cannabinoids, which can produce experiences similar to cannabis. New psychoactive substances are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
20. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances in prison can lead to debt, violence and intimidation.
21. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of new psychoactive substances. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of new psychoactive substances; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between new psychoactive substances and debt and bullying.

Key Events

22. Mr Simon Lane was remanded to HMP Bullingdon on 28 April 2015, charged with attempted robbery from his adoptive parents. At the time he went to prison, Mr Lane had been prescribed mirtazapine (medication for depression) and had previously taken olanzapine (antipsychotic medication). Mr Lane had been to prison several times before. Prison staff had managed him under ACCT procedures once before in 2010, although they had only monitored him for one day.
23. Police staff noted in the Person Escort Record (PER, a form that accompanies prisoners on all journeys which communicates information including about risk factors) that Mr Lane had previously thrown himself in front of traffic. They did not record when this was, although Mr Lane later said that it had happened several years earlier.
24. At Bullingdon, Mr Lane completed a four-week methadone reduction programme (methadone is a heroin substitute). A prison GP prescribed mirtazapine. No one began ACCT procedures when Mr Lane arrived at Bullingdon, or during his time in prison.
25. On 20 August, Mr Lane transferred to HMP Winchester after a court appearance. He was no longer prescribed mirtazapine, although there is no record of why this stopped.
26. On 30 October, Mr Lane was sentenced to three years and nine months in prison. He was transferred to HMP Guys Marsh on 10 November. An officer interviewed Mr Lane on his first night, noting that she had no concerns about him harming himself.
27. On 16 November, a mental health nurse assessed Mr Lane. This was a standard assessment for all new prisoners as part of their induction. Mr Lane said that he had jumped in front of a bus in 2004 after an argument with his then partner. He said that he had no current thoughts of harming himself, but this might change, as he had no family support in prison. Mr Lane said he had no current issues with his mental health, but had previously had psychosis and heard voices. He said the most recent incident was in April, on the day of his offence. The nurse did not refer Mr Lane to the mental health team because he had no current symptoms of mental illness. She advised him to contact the mental health team if his symptoms returned.
28. A substance misuse worker saw Mr Lane for an induction assessment on 26 November. Mr Lane said he did not use drugs and did not need to work with the substance misuse service.
29. On 31 December, Mr Lane moved from the induction unit to Mercia Unit, a standard residential unit. On 20 January 2016, prison officers found Mr Lane seemingly under the influence of drugs. His personal officer recorded that Mr Lane was disoriented and could barely speak.
30. On three further occasions in the next month, officers found Mr Lane under the influence of drugs. Prisoner A, who was friends with Mr Lane, said that Mr Lane

smoked a lot of 'Spice' (a new psychoactive substance) when he lived on Mercia Unit. He did not think that Mr Lane showed any side effects from using the drugs, but said he was in debt to other prisoners because of his drug use. He said this was a manageable amount of debt and that Mr Lane understood prison life and knew how to get by. However, he said that another prisoner showed him a video clip on a mobile phone of Mr Lane allowing another prisoner to punch him in return for Spice. None of the prison staff we spoke to were aware of this incident.

31. On 12 March, after again finding Mr Lane under the influence of drugs, his personal officer referred him to the substance misuse team. The officer said that Mr Lane seemed keen to work with the substance misuse team.
32. A substance misuse recovery worker assessed Mr Lane on 18 March. She said that Mr Lane was very engaged and appeared relaxed. Mr Lane said that he had attempted suicide in the past, sometimes had thoughts of harming himself again and that sometimes these were more than just thoughts. She said she understood this to mean that Mr Lane had 'ups and downs' but that it did not necessarily mean he would act on his thoughts. The recovery worker asked Mr Lane if he felt he needed to be monitored under ACCT procedures, and he said he did not think this was necessary. Mr Lane said that other prisoners had threatened him on Mercia Unit and that he wanted to move to another unit. The recovery worker said that Mr Lane would not say why he had been threatened, but she assumed that it was related to his drug use. Mr Lane said that he felt very alone in prison as he did not have contact with any of his children and did not receive visits. The recovery worker referred Mr Lane to the mental health team. She considered opening ACCT procedures, but chose not to do so as she said Mr Lane presented well and did not appear vulnerable. Instead, she telephoned a safer prisons administrator and spoke to her about her concerns for Mr Lane.
33. The safer prisons administrator said that the substance misuse recovery worker told her that Mr Lane was quite anxious and his mood was low. She did not remember her speaking about any other issues Mr Lane had. The safer prisons administrator said she advised the recovery worker to speak to staff on Mr Lane's unit and ask them to keep an eye on him.
34. The substance misuse recovery worker spoke to the drug recovery lead about moving Mr Lane to Saxon Unit, the drug treatment and recovery unit, because of the threats he had received on Mercia Unit. Mr Lane moved to a single cell in Saxon Unit later that day but she did not speak to officers there about Mr Lane's fears for his safety.
35. The mental health team discussed Mr Lane's referral at their weekly meeting on 22 March. They added him to their waiting list for a triage assessment.
36. Prisoner B lived in the cell next to Mr Lane on Saxon Unit. He said Mr Lane smoked a lot of Spice and subsequently had a lot of debt. At around 5.15pm on 23 March, Mr Lane told him that another prisoner had approached him about the debt for Spice he had accumulated on Mercia Unit. He said Mr Lane told him he was in trouble, but did not appear too worried. He said he and Mr Lane then

shared a joint of Spice, and Mr Lane prepared another one to smoke after they were locked in their cells at night.

37. At 8.45pm, an operational support grade (OSG) and the night patrol officer started work on Saxon Unit. At around 11.30pm, Mr Lane rang his cell bell to call the OSG to the cell. Mr Lane said that other prisoners were bullying him and he needed to move to Cambria Unit. (Cambria Unit is a unit for vulnerable prisoners and those serving longer sentences. It is situated away from the main residential units.) The OSG thought he spoke to Mr Lane for three or four minutes, and recalled that Mr Lane spoke very quietly as if he did not want anyone to overhear what he said. He said he did not think Mr Lane appeared scared, and told him he would speak to the unit officers the next morning about his request. He said that he did not consider calling the night manager to speak to Mr Lane, as his request was not unusual and the night manager would not be able to arrange a unit move. He said that Mr Lane did not indicate that he would harm himself, and he did not therefore consider starting ACCT procedures.
38. Mr Lane rang the cell bell again at around 5.30am on 24 March. He asked the OSG for paracetamol, as he said he had a headache that had kept him awake all night. He told Mr Lane that he could not issue paracetamol but that he could get some from healthcare staff in the morning.
39. The OSG conducted a count of prisoners at around 5.45am. He recalled that Mr Lane was sitting on his bed smoking a cigarette.
40. At around 7.30am, Officer A relieved the OSG. In his handover, the OSG told the officer that Mr Lane had asked to move to another unit. The officer then began a count of prisoners. When he arrived at Mr Lane's cell, he found that Mr Lane had covered the observation panel with a sheet. He spoke to Mr Lane, but could not remember if Mr Lane responded. He did nothing further but continued counting prisoners.
41. Officer B arrived on Saxon Unit shortly after 7.45am. Officer A explained that Mr Lane had covered his observation panel and had told the PSG that he wanted to move to another unit. Officer B said he did not consider going to Mr Lane's cell immediately as he assumed that the OSG and Officer A had already spoken to him.
42. Around five minutes later, a Supervising Officer (SO) arrived on Saxon Unit. Officer B then began a count of the prisoners in their cells. When he arrived at Mr Lane's cell, he found the observation panel still covered. Officer B tried to open the door, but found that Mr Lane had put furniture behind the door to create a barricade and prevent staff from opening it. Officer B could partially open the door, and saw Mr Lane hanging from a bed sheet that he had tied to the window bars. He radioed a medical emergency code blue, indicating a life-threatening situation. The communications officer recorded the call at 7.58am, and called an ambulance.
43. Officer A, the SO, and other prison staff arrived and tried to open the cell door. Officer C opened the door sufficiently to enter the cell, and went in and cut the ligature. A custodial manager began cardiopulmonary resuscitation and the SO applied a defibrillator. A nurse took over when she arrived shortly afterwards,

and a healthcare assistant helped her. The defibrillator advised them not to apply an electric shock and to continue with chest compressions.

44. Paramedics arrived at Guys Marsh at 8.18am and at Mr Lane's cell at 8.20am. They initially continued cardiopulmonary resuscitation, but recorded that Mr Lane had died at 8.40am.

Contact with Mr Lane's family

45. A prison chaplain and a family liaison officer visited Mr Lane's parents on the morning of 24 March, and informed them of Mr Lane's death. Mr Lane's funeral was held on 6 April. In line with Prison Service instructions, the prison contributed to the costs.

Support for prisoners and staff

46. After Mr Lane's death, the duty operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
47. The prison posted notices informing other prisoners of Mr Lane's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Lane's death.

Post-mortem report

48. A post-mortem established the cause of death as ligature suspension. Toxicology tests found no evidence of illegal or unprescribed drugs or new psychoactive substances in Mr Lane's blood.

Findings

Identifying risk of suicide and self-harm

49. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Guys Marsh should have recognised Mr Lane as at risk and begun ACCT procedures to support him.
50. Mr Lane had a number of risk factors for suicide and self-harm, and we are concerned that he highlighted many of these at his assessment with the substance misuse worker on 18 March. Mr Lane said he had attempted suicide in the past, had thoughts of doing so again and that sometimes this went beyond thoughts. Mr Lane said he had been threatened by other prisoners, and he was therefore potentially at risk of violence. It was commonly known that Mr Lane smoked 'Spice', a new psychoactive substance. There are concerns that these substances can produce a range of reactions and might increase the risk of suicide and self-harm. Mr Lane had been treated by mental health services in the past. He also said he felt isolated in prison and did not have any contact or support from his family.
51. The substance misuse recovery worker recognised that Mr Lane had ongoing issues and, appropriately, spoke to her line manager and the safer prisons department about her concerns. However, she based her judgement on whether to begin ACCT procedures on Mr Lane's presentation at the time of the assessment. While this is important, we found, in a PPO thematic report into risk factors in self-inflicted deaths, that assessments of risk too often place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. In another PPO thematic report, into self-inflicted deaths in 2013-14, we found that staff too rarely considered that bullying, debt and drugs issues made prisoners more vulnerable and could increase the risk of suicide.
52. We consider that staff at Guys Marsh should have been more alert to Mr Lane's risk factors for suicide and self-harm. In particular, we consider that the substance misuse recovery worker should have begun ACCT procedures on 18 March. However, we recognise that she told us that she has never been trained in ACCT procedures (a mandatory requirement of PSI 64/2011 for all staff). We make the following recommendation:

The Governor should ensure that all staff have a clear understanding of their responsibilities to manage and support prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **All staff record, share and consider all relevant information about risk and open ACCT procedures when indicated.**
- **All staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011.**

Bullying

53. Guys Marsh has a local violence reduction strategy which highlights the process of raising and investigating any identified or suspected act of aggression, bullying, intimidation or violence. Any member of staff who witnesses or is told of such an act, should complete a case note entry on NOMIS (a prison-wide IT system). The safer prisons team then assigns a supervising officer to investigate. Perpetrators and victims should have an 'alert' created on NOMIS, so they can be identified as such on a daily list that is printed for each residential unit.
54. On 18 March, Mr Lane told a substance misuse recovery worker that other prisoners on Mercia Unit had threatened him, which she understood related to his drug use. Prisoners who knew Mr Lane said that he was in debt to other prisoners because of his drug use. Mr Lane said he wanted to move to another unit, which she helped to arrange. However, no one completed the required NOMIS entries to highlight Mr Lane as a potential victim of violence and to initiate an investigation. Those staff on Saxon Unit to whom we spoke thought Mr Lane had moved to the unit because of his drug use (Saxon Unit is designated as a drug treatment wing). They did not identify him as a potential victim and therefore did not monitor him as one. Mr Lane's neighbour on Saxon Unit told us that Mr Lane continued to be threatened after his move to the unit.
55. A PPO publication of June 2011 found there was evidence of bullying and intimidation in 20 per cent of self-inflicted deaths we investigated. In our PPO thematic report into self-inflicted deaths in 2013-14, we found that reports or suspicions that a prisoner is being threatened or bullied, or is vulnerable due to debt, need to be recorded, investigated and robustly responded to. We make the following recommendation:

The Governor should ensure that all information about bullying, intimidation and the use of drugs is fully coordinated and investigated; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situations.

New psychoactive substances

56. Prisoners who knew Mr Lane told us that he frequently used Spice in prison. Residential officers on Mercia Unit found him seemingly under the influence of drugs on several occasions in 2016. It was only on the fifth occasion, in March, that his personal officer referred Mr Lane to the substance misuse team.
57. HM Inspectorate of Prisons, in their inspection of November 2014, found that the supply of new psychoactive substances was the driving force behind significant levels of violence at Guys Marsh. In its most recent annual report, the IMB at Guys Marsh highlighted this as a significant concern.
58. In July 2015, we published a Learning Lessons Bulletin about the deaths associated with use of new psychoactive substances. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better

awareness among staff of the dangers of new psychoactive substances; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. While Guys Marsh has a drug and alcohol strategy, this provides no focus on the prevalence and dangers of new psychoactive substances. We consider it important that Guys Marsh does all it can to eradicate the use of new psychoactive substances. We make the following recommendation:

The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that staff are vigilant for signs of its use and are briefed about how to respond when a prisoner appears to be under the influence of such substances.

Overnight events on 23-24 March

59. The night officer, an OSG, said that Mr Lane called him to his cell at around 11.30am on 23 March. Mr Lane said he wanted to move to another unit as other prisoners were bullying him. He spoke quietly, which led the OSG to think that he did not want anyone to overhear.
60. The OSG took no action other than to tell Mr Lane that he would pass his request to residential officers in the morning. He did not consider consulting the night manager, as he did not think that Mr Lane's request was unusual and the night manager could not arrange a move. However, had he called the night manager to the unit, they could have taken Mr Lane out of his cell and given him the opportunity to speak freely about his issues. This would also have given them additional evidence to consider Mr Lane's risk of suicide and self-harm. The OSG said he did not consider starting ACCT procedures as Mr Lane presented well and did not appear vulnerable. We are not satisfied that he fully considered Mr Lane's risk factors. We make the following recommendation:

The Governor should ensure that night patrol officers inform the night orderly officer whenever a prisoner indicates they are at risk of bullying or violence, that they consider all relevant information about risk and open ACCT procedures when indicated.

Blocked observation panel

61. Guys Marsh's Notice to Staff 178/2015 tells prison staff what to do if they find a cell observation panel obscured. It says that staff should make every effort to encourage dialogue and negotiation, and either ask the prisoner to remove the obstruction or enter the cell and remove the obstruction. If they are unable to see or speak with the prisoner, staff should radio for help from other staff or the orderly officer, and remain at the door. If they believe the prisoner may be at risk, they should assess the risk of opening the cell door before help arrives.
62. Officer A said he spoke to Mr Lane when he found his observation panel covered, but could not remember if Mr Lane responded. He took no further action and left the cell. In line with local instructions, he should have immediately asked for help and, given the information he had received from the OSG, considered immediately trying to open the cell. Both officers and the SO should also have immediately tried to communicate with Mr Lane, or open his cell, when

they arrived for duty and Officer A briefed them on the morning's events. We make the following recommendation:

The Governor should ensure that prison staff respond to blocked observation panels in line with local instructions, including that they enter cells as quickly as possible if there is information that the prisoner may be at risk.

**Prisons &
Probation**

Ombudsman
Independent Investigations