Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Flynn a prisoner at HMP Swaleside on 25 March 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

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

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

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

On 25 March 2015, Mr Darren Flynn was killed by stabbing at HMP Swaleside. He was 46 years old. I offer my condolences to Mr Flynn's family and friends.

On 18 September 2015, two other prisoners, prisoner A and prisoner B, were convicted of Mr Flynn's murder. The murder took place in the Pathways Unit at Swaleside, a special unit that aims to address emotional, relationship and behavioural difficulties, and reduce the risk of particularly difficult prisoners.

Homicides in prison are rare and identifying those likely to carry out such killings can be difficult. The investigation identified some lessons for future improvements, including more effective searching of the unit and closer scrutiny of intelligence information when assessing a prisoner's suitability for the Pathways Unit. However, I am satisfied that each of the men met the criteria for the unit. Each of the men, in common with the other prisoners in the unit, and indeed in the rest of Swaleside, had a history of violence. While both the prisoners had a record of violent behaviour in prison, there was no information to suggest that they would be a specific danger to other prisoners in the unit, or that they were a particular risk to Mr Flynn. Both the prisoners' actions were sudden and unexpected and I consider that it would have been very difficult for prison staff to have predicted or prevented Mr Flynn's death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2016**

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Summary

Events

1. In 2007, Mr Darren Flynn received an indeterminate sentence for wounding with intent. He had a history of substance misuse, self-harm and violence to others in prison, including staff. Mr Flynn had been at HMP Swaleside since October 2014, and in January 2015, he was moved to the Pathways Unit at the prison. (The pathways service forms part of the national offender personality disorder strategy. It is designed to support and prepare high-risk offenders with emotional, relationship and behavioural difficulties to progress in the prison system.)

2. In 2001, prison A received a life sentence for murder. During his time in prison, he had assaulted other prisoners and there was intelligence about him threatening staff and prisoners, as well as allegations that he had planned to kill three other prisoners. In January 2015, he was transferred to Swaleside. He joined the Pathways Unit in February.

3. In 2011, prisoner B received an indeterminate sentence for grievous bodily harm. During his time in prison, he had assaulted another prisoner, and there was intelligence that he had threatened and assaulted staff, had weapons, threatened to take a hostage and threatened to kill another prisoner. In November 2014, he was transferred to Swaleside. At the end of February 2015, he was accepted on the pathways programme and moved to the Pathways Unit.

4. Mr Flynn settled well in the Pathways Unit, attended engagement groups and interacted appropriately with other prisoners. On the morning of 25 March 2015, prisoner B, and Mr Flynn took part in a group therapy session, which Mr Flynn left for a while. He said he had been upset when the group discussed sex offenders and abuse. Prison B told the group that he was annoyed that Mr Flynn had looked at him, as if to accuse him of being a sex offender. That evening, prisoner A and prisoner B killed Mr Flynn by stabbing him with weapons they had made. The two men were convicted of murder on 18 September 2015.

Findings

5. The two prisoners and Mr Flynn had a history of violence in prison. They had all been assessed as suitable for the Pathways Unit, although staff did not know the full details of the intelligence information about them. However, we are satisfied that all three were appropriately assessed as suitable for the programme, as it was designed for violent high-risk offenders. Had staff seen the full intelligence information, it would not have excluded them, but it might have informed their further assessments and management plans. In the days before Mr Flynn's death, there was no intelligence to suggest that he was at risk of attack, and it would have been difficult for anyone to have predicted the actions of both the prisoners.

6. Despite the apparent prevalence of weapons among prisoners at Swaleside, and the particular risks of the prisoners in the Pathways Unit, there were no random cell searches. All cell searches at the prison were targeted, based on

intelligence received. There was no current intelligence information against the two prisoners so their cells had never been searched for weapons.

7. Although it would not have affected the outcome for Mr Flynn, we concluded that Swaleside needs to scrutinise intelligence information more closely when assessing a prisoner's suitability for the Pathways Unit and that the searching strategy should reflect the particular concentration of dangerous and volatile prisoners in the unit.

Recommendations

- The Governor and the Head of the Pathways Unit should ensure that all relevant security information is taken into account as part of the assessment process when prisoners apply for the pathways programme, and is used to inform their future management and assessments of risk in the unit.
- The Governor should ensure that Swaleside has an effective security and searching strategy, which reflects the particular risks of prisoners in the Pathways Unit.

The Investigation Process

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

9. On 23 April 2015, the investigator met police officers investigating Mr Flynn's death. In line with the Ombudsman's terms of reference, we suspended our investigation while the police carried out a criminal investigation. Two other prisoners were charged with Mr Flynn's murder and were convicted on 18 September 2015. Our investigation continued to be suspended at the request of the Crown Prosecution Service and resumed after the conclusion of the criminal trial.

10. NHS England commissioned a clinical reviewer to review Mr Flynn's clinical care at Swaleside. The clinical reviewer had access to the medical and Pathways Unit records for both the prisoners.

11. The investigator visited Swaleside and obtained copies of relevant extracts from Mr Flynn's and the two prisoners' records. He interviewed 16 members of staff at the prison in January and February 2016. The clinical reviewer joined the investigator for some of the interviews. The two prisoners did not respond when the investigator asked if they would be interviewed for the investigation.

12. We informed HM Coroner for Mid Kent and Medway of the investigation. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Flynn's next of kin, a long-term friend, to explain the investigation. She had no specific matters for our investigation to consider.

14. Mr Flynn's next of kin received a copy of the interim report. She raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Swaleside

15. HMP Swaleside is part of the Isle of Sheppey group of prisons, which includes HMP Elmley and HMP Standford Hill. Swaleside's main function is to hold prisoners serving life sentences, but it also holds prisoners serving determinate sentences. The prison can hold up to 1,112 men. Integrated Care 24 Ltd (IC24) provides primary healthcare at Swaleside. There is 24-hour primary care nursing cover, and a 17-bed inpatient unit. The Minster Medical Group provides GP services, including an out of hours GP service.

The Pathways Unit at Swaleside

16. The Pathways Unit on F wing at Swaleside started in January 2014, as part of the national offender personality disorder strategy. The unit is a joint operation between the National Offender Management Service and the London Pathways Partnership. The unit takes up to 60 men. Participation is voluntary and designed for violent and high-risk prisoners, who are serving relatively long sentences and have emotional, relationship and behavioural difficulties. It aims to address offenders' behaviour to help them progress in completing sentence plans, with a view to progress to life in the community. The aim is for prisoners to maintain their own and others' safety while improving their psychological, social and physical wellbeing. The work of the unit incorporates the principles of the psychologically-informed, planned environment (PIPE). A key principle of PIPE is that relationships play a central role.

17. Prisoners in the unit follow a two-stage process. The first is the engagement stage which typically lasts six months and gives prisoners the opportunity to be ready to engage in the treatment plan. Once this stage is complete, prisoners are assessed to see if they are suitable for the second stage - the treatment service - at the unit, Treatment is designed for those who are not ready or suitable for more intensive treatment programmes, such as those offered in therapeutic communities at HMP Grendon or HMP Dovegate.

18. Prisoners must meet the following criteria for acceptance for the Pathways Unit at Swaleside.

- They must have at least 18 months left to serve.
- They must be a category B or C prisoner.
- They must understand the purpose of the unit as a means of progression and eventual effective resettlement.
- They must have been assessed during their sentence as being at high risk of serious offending and posing a high or very high risk of harm.
- Their risk is linked to their personality difficulties or disorder.
- Their progression through their sentence plan is likely to be helped by taking part in the pathways unit.
- They must not have been convicted of a sexual offence. (Swaleside has historically not held sex offenders.)

19. Clinicians working on the offender personality disorder programme use a formulation-based approach, which considers prisoners' experiences in a contextual and explanatory framework. The aim is to raise prisoners' awareness of their behaviour, thoughts and emotions, and for operational and clinical staff to understand their behaviour and interactions to inform interventions.

HM Inspectorate of Prisons

20. The report of the most recent inspection of Swaleside in April 2016 has not yet been published, but initial feedback from inspectors was that levels of violence at the prison were far too high, despite a 'zero-tolerance' approach to weapons. Many prisoners felt unsafe and while initiatives to address these issues were developing, they were not yet embedded. Inspectors said that prisoners were complimentary about staff in the Pathways Unit but were concerned about the disruption caused by prisoners living in the unit, but not taking part in the pathways programme. However, inspectors considered that the programme was an excellent approach to interacting with, treating and progressing prisoners with very challenging behaviour and personality disorders. They considered that the unit supported the prison's work to make the whole establishment safer.

21. At the previous inspection of Swaleside in April 2014, inspectors said that prisoners were concerned about the availability of weapons in the prison. Inspectors reported there had been a number of serious assaults, including nine incidents in the previous 12 months when prisoners had been stabbed or slashed with weapons. Inspectors found that the security department understood the current and emerging threats to safety, including the perceived increase in the availability of weapons, but it was not clear what action was being taken to address this. The Pathways Unit was not inspected at the 2014 inspection, as it was in the early days of development.

Independent Monitoring Board

22. 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 April 2015, the IMB reported that the prison had become more unstable and there had been an increase in assaults on prisoners and on staff. Prison staff often found weapons of increasing sophistication, but intelligence-led security had stopped many incidents. The IMB noted that there were plans to extend the pathways service on F Wing for men who had completed treatment.

Previous deaths at HMP Swaleside

23. Mr Flynn's murder was the first homicide at Swaleside since the Prisons and Probation Ombudsman began investigating deaths in prisons in April 2004.

Key Events

Mr Darren Flynn

24. In 2007, Mr Flynn received an indeterminate sentence for wounding with intent. He had stabbed his victim with a knife and had initially been charged with attempted murder. Mr Flynn had a history of substance misuse, self-harm and violence in prison, including towards staff. He had been monitored as at risk of suicide and self-harm many times. From 2011, until the time he died, Mr Flynn took prescribed antidepressants. He was not under the care of the prison's mental health team.

25. In May 2014, when Mr Flynn was at HMP Erlestoke, his offender supervisor discussed with him whether he might be suitable for the pathways programme. He moved to HMP Dartmoor in late June 2014 and then to HMP Exeter in early July 2014. While at Exeter, he was diagnosed with a personality disorder. Mr Flynn agreed to be referred under the offender personality disorder pathway.

26. On 9 August 2014, Mr Flynn was transferred to Swaleside. On 6 November, staff began to monitor him under Prison Service suicide and self-harm prevention procedures, after he made cuts to his neck. Staff supervised him constantly and during this time, he threw hot water over three members of staff. They ended ACCT monitoring on 13 November.

27. On 18 November, Mr Flynn was referred to the Pathways Unit at Swaleside, and had an informal meeting with unit staff. On 12 December, a psychologist at Swaleside, assessed Mr Flynn following his referral. The psychologist noted Mr Flynn's previous history of violence and gathered other information about his suitability. She noted that Mr Flynn was physically disabled and walked with difficulty, using crutches. She did not complete the sections of the assessment headed 'evidence / intelligence of current risk to others' or 'vulnerability'. She noted that Mr Flynn appeared suitable for the pathways programme and was keen to engage. She told him that staff would discuss his referral the next week and let him know the outcome.

28. On 21 December, Mr Flynn was accepted for the engagement stage of the programme. The next day, he self-harmed and staff began monitoring him again under suicide and self-harm prevention procedures. This ended on 30 December.

29. It is unclear when Mr Flynn officially started the pathways programme. The notes of a referrals meeting on 5 January 2015 said that he had started the programme, but was living on another unit, due to his recent self-harm. Members of the pathways team were in contact with Mr Flynn, and the plan was for him to move to the unit within the next two weeks. On 7 January, Mr Flynn told a substance misuse worker, that he was moving to the Pathways Unit the next week.

30. On 30 January, Mr Flynn met his key worker in the Pathways Unit, a clinical psychologist, and Officer A. Mr Flynn said he was 'in a good place' and had settled in the unit. He said that he preferred to keep himself to himself and had had not any recent thoughts of harming himself. He kept occupied by making matchstick models. The clinical psychologist noted that Mr Flynn wanted to work

on his impulsivity. He acknowledged that he often got upset, which led him to do things he later regretted.

31. A summary report about Mr Flynn's behaviour and interactions (known as the formulation) noted that he was aware of his personality difficulties, acted impulsively and made quick decisions, which he later regretted. It noted that his impulsive behaviour appeared to be a way of coping with overwhelming emotions. It was planned that Mr Flynn would spend six to nine months on the engagement stage of the pathways programme before progressing to the treatment service. He was keen to start the treatment element, as he wanted to move to a prison therapeutic community, such as HMP Grendon.

32. On 9 March, at a key worker session with the clinical psychologist, Mr Flynn said that he had been upset about the murder of a young girl, which had been in the news recently, but had coped. He said that things on the wing were good and that he had stayed out of trouble for six months. She noted that this was an achievement for him. She noted that Mr Flynn was vice-chairman of the community meeting and that he attended a number of social and creative activities and structured groups. She recorded that he was looking forward to starting treatment in the future.

33. Officer B said that Mr Flynn did not interact much with other prisoners. Officer C said Mr Flynn needed a lot of attention, but was quiet. He often got into debt by borrowing tobacco from other prisoners.

34. On 5 March, Officer D noted in Mr Flynn's record after a meeting with prisoners, that he was quiet but able to draw on personal experiences, listened well and spoke when appropriate. On 21 March, he noted that Mr Flynn continued to attend engagement groups and interacted appropriately with others.

35. At an addictions group on 24 March, Mr Flynn talked about his early life and drug abuse. He became upset when another prisoner said he needed to accept that he would never change.

Prisoner A

36. In 2001, prisoner A received a life sentence for murder. He had stabbed a friend to death during an argument. Throughout his time in prison, there were many security intelligence reports about him threatening staff and prisoners, particularly sex offenders. There were intelligence reports of him having weapons and mobile phones and being involved in intimidation, bullying and fighting. He was also associated with drugs and illicit alcohol in prison. In 2003, it was alleged that he had attacked another prisoner with a knife. In 2007, he threatened to stab another prisoner. In 2008, there was intelligence suggesting that he had threatened to stab a member of staff. During his time in prison he had no significant contact with the prison's mental health services.

37. In 2011, intelligence reports indicated that prisoner A and another prisoner were planning to kill three other prisoners and had practised the assault in their cell. The reports said that prisoner A wanted publicity so he would be moved to a psychiatric hospital. In 2012, he assaulted a prisoner convicted of sexual offences and threatened to chop him up. In 2013, it was alleged that he had

been involved in stabbing another prisoner. Prison staff reported this to the police, but they did not pursue it.

38. In August 2014, prisoner A assaulted a prisoner by throwing a pan of hot oil over him and chased him with a homemade weapon. He later told staff that he had intended to stab the prisoner. He was held in the segregation unit. In October, staff noted that he was sometimes disruptive and verbally abusive to staff and other prisoners in the segregation unit, but mostly complied with the regime. In November, he asked about his long-term plans and the courses he had to take as part of his sentence planning. However, days later, he said that if was relocated, he would 'kill all them nonces'.

39. An undated entry in his risk assessment document (OASys) noted that prisoner A had issues with prisoners who had committed sexual offences and that, due to previous incidents, his risk to other prisoners was high. The entry noted that it was more likely than not that he would attack someone imminently and that the impact would be serious.

40. On 5 December 2014, an officer at Full Sutton noted that although he mostly complied with the segregation unit regime, prisoner A was prone to child-like outbursts, wound up other prisoners and was relentless in his abuse. On 17 December, his personal officer noted that his banter with staff and prisoners could escalate to threats. He noted that he was eager to move on from the segregation unit and transfer to a prison that ran suitable offending behaviour courses. On 4 January 2015, his personal officer discussed with him a planned move to Swaleside. Prisoner A wanted to be considered for the pathways programme but was concerned that he might end up in the segregation unit at Swaleside, if he was not accepted for the programme.

41. On 27 January, prisoner A transferred from Full Sutton to Swaleside. He said that he had been moved to Swaleside to take part in the programme offered in the Pathways Unit. However, staff at Full Sutton had not formally referred him for the pathways programme. On 29 January, the psychologist at Swaleside and Officer E met him and gave him information about the Pathways Unit. The psychologist told prisoner A that they would discuss his application at the next referrals meeting on 2 February. The summary of the referrals meeting said that he was a complex person who was suitable for the engagement stage of the programme.

42. On 5 February, a forensic psychologist, interviewed prisoner A for an initial assessment. In her record of the interview, she described him as engaged and polite. He said he had behavioural problems and had left school without any qualifications. He said that he needed to complete relevant programmes before he could become a category C prisoner. On 9 February, he was told that he had been accepted for a place in the Pathways Unit.

43. An undated and unsigned admissions form noted that prisoner A had previously dropped out of two therapeutic communities, as he had been frustrated by the process. He had been removed from Grendon because of his homophobic attitude. He had completed a number of behavioural courses, but these had resulted in minimal improvement. The form noted that he had thrown hot oil over another prisoner, who he thought was a sex offender.

44. On 16 February, the forensic psychologist had a key worker session with prisoner A. She noted that he was settling in well and he told her he had no difficulties with most prisoners, but did not get on with some. He said he got bored easily and they talked about him engaging in unit activities.

45. On 9 March, prisoner A told the forensic psychologist that his behaviour in prison was probably the reason why he was not a category C prisoner. She noted he did not have a clear target about lowering his risk. At a community meeting, he had said he was frustrated about the behaviour of another prisoner in the unit who was disruptive and threatening. (The prisoner was not Mr Flynn). He told her that he was keen to move to the treatment stage of the pathway programme, but understood it might be two years before he completed the programme.

46. The summary of prisoner A's behaviour and interactions (his level one formulation) noted he had a history of disengaging from interventions. It said he recognised that he struggled to apply what he had learnt, and that this limited his progress. It said his challenging behaviour towards staff, which appeared linked to emotional impulsivity, impacted on his progress. On 21 March, Officer D noted that he had settled in well, attended groups and engaged in unit social activities.

47. On 23 March, the forensic psychologist spoke to prisoner A about other treatments. She noted that it was difficult to engage with him. He seemed deep in thought, was holding back from contributing fully, and was not forthcoming about how he had been feeling over the previous weeks. She set him a number of targets and noted he was keen to start the treatment stage of the pathways programme as soon as possible. She talked with him about how he tended to get over-excited, which led to some of the things he said being misinterpreted.

Prisoner B

48. In 2011, prisoner B received an indeterminate sentence for grievous bodily harm, after stabbing a taxi driver in the neck. He had initially been charged with attempted murder and had a history of violence. Between 2011 and 2015, he was the subject of a number of intelligence reports in prison, including threats and assaults against staff, possession of weapons and threatening to take a hostage. A report in 2011, noted that he might act violently towards anyone who irritated him. In 2012, he held a razor to a prisoner's neck. In 2013, he was reported for his intimidating and unpredictable behaviour, for assaulting another prisoner, and for threatening kitchen staff with a knife.

49. In May 2014, prisoner B said he intended to cut a prisoner's throat or break their neck. He had no specific target but said he had made a weapon and would hurt anyone, particularly if they looked like a sex offender. He handed over two handmade weapons and staff segregated him.

50. In July, staff found a homemade weapon in his cell. He was abusive during a treatment programme session and asked whether he could transfer to a therapeutic community like Grendon, to address his anger issues. In September 2014, he was seen on camera making a stabbing motion behind another prisoner's back and was segregated again. In November, there were intelligence reports that he had made serious threats that he intended to assault staff.

51. Prisoner B's risk assessments noted that he had a history of serious harm to others and that his behaviour had become progressively violent over time. He was regarded as a medium risk to other prisoners, meaning that he could potentially harm others, but was unlikely to do so unless his circumstances changed.

52. On 20 November, prisoner B transferred from Garth to Swaleside and on 10 December, he referred himself to the Pathways Unit.

53. On 28 January 2015, the psychologist at Swaleside, the Pathways Unit clinical lead for engagement and Officer E assessed prisoner B. The psychologist noted that he had a diagnosis of anti-social personality disorder, but denied having any difficulties with staff or prisoners. She noted that although he had not faced formal disciplinary proceedings for several months, he had a history of violence in prison and had not completed other courses due to his negativity and his challenging behaviour to staff. She made an initial decision that he would be likely to benefit from the pathways programme.

54. On 6 February, at a meeting with the substance misuse worker, prisoner B said he did not want to move to the Pathways Unit and made sexually inappropriate comments. She said she felt that he was testing boundaries. On 16 February, he was accepted onto the pathways programme and moved to the unit on 27 February. An undated and unsigned, admissions form noted that he had left previous programmes due to his challenging behaviour. It said that in 2014, he had been disciplined for stabbing another prisoner and had a known history of violence in prison.

55. On 16 March, the substance misuse worker reported that prisoner B was settling well. However, at a key worker session on 20 March, he told her he was unhappy in the unit, but could not explain exactly why. She suggested that he should list the things he would like to see improved. She noted that he was vocal during group meetings and engaged well. However, some of his contributions had a negative impact on other group members.

56. The summary of prisoner B's behaviour and interactions (his level one formulation) noted that he had not completed previous engagement programmes due to aggressive behaviour. It said that he was sensitive to potential threats from others and could react aggressively in anticipation of physical danger towards him. During his time in prison, he had had no significant contact with mental health services.

Events of 25 March 2015

57. At 9.30am on 25 March, an assistant psychologist, and Officer F held a group therapy session in the Pathways Unit about factors that contributed to or were associated with paranoia. Prisoner B, Mr Flynn, and a few other prisoners attended. The assistant psychologist said prisoner B was challenging during the meeting, but not aggressive. She said he had a "know it all" approach. He identified that negative childhood experiences, such as child abuse, could contribute to paranoia.

58. One of the prisoners, who was at the group therapy session, said that they had discussed sex offenders and Mr Flynn then walked out of the meeting. After Mr Flynn left, prisoner B told the group that Mr Flynn had looked at him as if he had accused him of being a sex offender. The prisoner said during the meeting, prisoner B and prisoner A had bantered about gay sexual activity, and that was when Mr Flynn had walked out. The prisoner said he heard prisoner B say he was going to "do Mr Flynn in" later that day, after he had collected his order from the prison shop. The prisoner said that it was common knowledge on the wing that people were planning to attack Mr Flynn. Another prisoner said the group had discussed the subject of sexual abuse that day. He said that Mr Flynn was upset and left. He came back later, but still appeared upset.

59. The assistant psychologist said Mr Flynn came back a short time after he had left the group. He apologised for leaving and said the topic of abuse had triggered memories of things he had discussed with staff the previous day. Prisoner B told the group that they could not be expected to know about Mr Flynn's past. The assistant psychologist said Mr Flynn left the session again at 10.30am, to collect his medication, but did not come back, as planned. She wrote in Mr Flynn's case history that he had engaged well and had contributed to group discussions.

60. At 2.00pm, Prisoner A went to an art class. The assistant psychologist said she saw him there and he seemed in a good mood and was making jokes, but said he thought he should be in Broadmoor (a high security psychiatric hospital).

61. At 6.00pm, Officer B was speaking to another prisoner when a friend of Mr Flynn's, asked if he could collect Mr Flynn's canteen (shop order) on his behalf. Officer B gave him permission.

62. One of the prisoner said when he came back to the unit that evening, after spending some time outside in the exercise yard, he saw Prisoner A and prisoner B taking Mr Flynn into prisoner B's cell. He said he heard both of them tell Mr Flynn that they had some drugs for him.

63. At around 6.40pm, Officer C was talking to Officer G when prisoner B, who was with prisoner A, asked if he could speak to Officer G in private. Officer C said the prisoners appeared calm and he moved away to let them speak to Officer G. At about 6.45 pm, Officer G went with the prisoners to prisoner B's cell. We were unable to speak to Officer G, but in his statement for the police, he said that the two prisoners had told him there was a dead body in prisoner B's cell. At first, he had thought they were joking or making it up for some reason. Both the prisoners were very calm and matter of fact. He went into the cell and the two prisoners uncovered Mr Flynn's body, which had a quilt and pillow over it. He could get no response from him.

64. Officer G called to other officers for help. He radioed a medical emergency code red and asked healthcare staff to attend. (A code red indicates a medical emergency when there is severe loss of blood.) Officer C joined Officer G in prisoner B's cell. He said Mr Flynn was lying on the bed, face down with blood around his body and head. Officer C rolled Mr Flynn onto his back and checked for a pulse but he had none. He saw there were a number of puncture wounds in Mr Flynn's chest and he concluded that Mr Flynn was dead. Nurse A responded to the emergency call. When she arrived, she checked Mr Flynn for a pulse, but

found none. The nurse did not try to resuscitate Mr Flynn. She found no signs of life, and was satisfied he was dead and could not be resuscitated. (The post-mortem examination found that Mr Flynn had 190 puncture wounds to his body.)

65. An operational support grade officer, in the prison's control room received the emergency code red call. He was aware that paramedics were already in the prison, dealing with another emergency and asked them to go to the Pathways Unit. Paramedics arrived at the cell at 7.00pm. The paramedics did not administer any emergency treatment, as it was clear the Mr Flynn was dead.

66. Officers took the two prisoners to a wing office. The prisoners said they had killed Mr Flynn because he was a sex offender. Prisoner B told officers, "That's what happens to perverts. They shouldn't be on normal location." He said, "That's one less fucking nonce. He got what he deserved. That's one less paedophile to worry about." The officers asked prisoner B how he was sure that Mr Flynn was a sex offender. He shrugged and said, "It's done now anyway." (Mr Flynn was a not a sex offender and Swaleside does not take sex offenders.) The officers took both the prisoners to the segregation unit.

67. Prisoner A told officers that he and prisoner B had hidden the weapons they used in a bin under the stairs. Staff later recovered two bladed, homemade weapons.

68. At 7.03pm, the prison called the police who arrived at the prison at around 8.40pm. They spoke to staff in the Pathways Unit at 9.10pm. Both prisoners were taken into police custody for questioning on suspicion of murder and subsequently charged. On 18 September, 2015, they were convicted of Mr Flynn's murder.

69. On 26 March, the day after Mr Flynn's murder, a prisoner in the unit, a mental health nurse, that on 21 or 22 March, the two prisoners had asked him for sleeping tablets and had also asked him if he wanted to be involved in harming another prisoner. He had not informed anyone else at the time.

Contact with Mr Flynn's family

70. Mr Flynn had named a friend as his next of kin. As she lived a long way from Swaleside, a family liaison officer from a nearby prison informed her of Mr Flynn's death in the early hours of the morning of 26 March. The family liaison officer from Swaleside spoke to her later that morning about what had happened and a number of times after Mr Flynn's death. The prison contributed to the funeral expenses, in line with national instructions.

Support for prisoners and staff

71. Managers debriefed the prison staff involved in the emergency response and offered support. The prison told other prisoners of Mr Flynn'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 Mr Flynn's death.

Post-mortem report

72. A post-mortem examination found that Mr Flynn had died from multiple stab wounds to the chest.

Findings

Risk assessments

73. Swaleside assessed Mr Flynn, prisoners A and B as suitable for the Pathways Unit. Each of them met the criteria for the pathways programme and from the evidence we have seen, we are satisfied that each of them was properly assessed and there was no reason why they should have been excluded from the programme. The programme is designed for violent, high-risk prisoners. There was nothing in their records to suggest that they should not have been held in a unit together. Swaleside's population is comprised mainly of men who have been convicted of serious violent offences and they could have been held together on other wings in the prison, which also hold many dangerous men.

74. Oxleas NHS Foundation Trust, which is part of the London Pathways Partnership, run the Pathways Unit jointly with the National Offender Management Service. The Trust investigated Mr Flynn's death as a serious healthcare incident. Their investigation report noted that prison operational staff had checked the security information about the three prisoners before their assessment interviews for the Pathways Unit and did not report any issues to clinical staff, which might have led to any concerns about their suitability for the Pathways Unit.

75. The investigator reviewed the security intelligence information and found that while the clinical staff noted and took into account the three prisoners' history of violence when making their assessments, they were not fully aware of all their security risks. The two prisoners had a significant history of serious violence, including threats to harm other prisoners about which staff in the Pathways Unit were not fully informed. There were details of incidents in their intelligence records which would have been relevant for pathways staff in assessing the risk that they posed to others and in planning their future management.

76. We recognise that further scrutiny of the security intelligence is unlikely to have led to any of the prisoners being excluded from the pathways programme; it is more likely that the additional information would have reinforced the need for each of the prisoners to participate in the programme to help reduce their significant risks. However, we consider that staff involved in their therapy should have been aware of this further detail to help inform their management in the unit and assess their risk more accurately. We accept that this is unlikely to have changed the outcome for Mr Flynn.

77. One prisoner said that before the murder, he had heard prisoner B say he intended to harm Mr Flynn. He said this was common knowledge in the unit but there is no evidence that staff knew this. There was no security intelligence about this threat and no other security information indicating that Mr Flynn was at risk of attack.

78. We do not consider that staff could have been expected to predict and prevent the two prisoners' sudden and unexpected violence towards Mr Flynn on 25 March 2015. However, we consider that clinical staff should have as much relevant information as possible about prisoners from all sources, including the security intelligence system, when assessing prisoners suitability for the Pathways Unit. Such information should also inform their ongoing management

and assessment of risk in the unit. We make the following recommendation.

The Governor and the Head of the Pathways Unit should ensure that all relevant security information is taken into account as part of the assessment process when prisoners apply for the pathways programme, and is used to inform their future management and assessments of risk in the unit.

Searching

79. Prison Service Instruction (PSI) 68/2011, which sets out the national security framework on cell, area and vehicle searching says that all parts of the prison must be searched at a level and frequency set out in local security strategies agreed by the Governor and the deputy director of custody responsible for the prison. The instruction says that prisons not in the high security estate, do not need to carry out routine cell searches, but must conduct a local risk assessment to determine whether a programme of routine cell searching is needed, in addition to intelligence-led searching. The PSI says that all prisons must carry out intelligence-led searching, as appropriate. We were told that all cell searching at Swaleside is intelligence-led.

80. The PSI says that there must be arrangements for keeping records of searches and finds. The investigator asked the prison for information about how many cell searches had been carried out and how many weapons had been found in the Pathways Unit and the rest of the prison in the year before Mr Flynn's death. The prison did not have this information readily available.

81. In 2014, and again at the most recent inspection in April 2016, HM Inspectorate of Prisons was concerned about the level of violence at Swaleside and the use of weapons. The IMB reported that weapons of increasing sophistication were being found in the prison. Effective intelligence-led security relies on good staff relationships between staff and prisoners and good staff knowledge of what is happening in the prison but the inspectors found that this 'dynamic security' had been affected by staff shortages, inexperienced staff and less positive relationships than previously.

82. The clinical reviewer noted that more random searching took place in equivalent NHS units than in the Pathways Unit (where there was no random searching). The nature of the Pathways Unit means that it houses a concentration of particularly dangerous prisoners. Based on her experience of working in medium security units, where the profile of patients would be similar to those in the Pathways Unit, she was surprised that there was no detailed strategy for routine and random searching of the unit, and if necessary, of individuals.

83. We recognise that intelligence-led targeted searching can be effective, and is an efficient use of resources, but this relies on good dynamic security. We are concerned that the prison did not have readily available information about the level of finds through intelligence-led searching in the unit. One prisoner told us that it was 'common knowledge' that prisoner B intended to attack Mr Flynn, but none of the staff were aware of this. As noted above, pathways staff were not fully aware of some of the security intelligence about the prisoners' propensity for violence against other prisoners. We are not persuaded that the current

searching arrangements fully reflect the risks of the prisoners in the unit and protect the safety of prisoners and staff. We make the following recommendation.

The Governor should ensure that Swaleside has an effective security and searching strategy, which reflects the particular risks of prisoners in the Pathways Unit.

Clinical care

84. The clinical reviewer assessed Mr Flynn's clinical care at Swaleside. She was satisfied that he was appropriately placed in the Pathways Unit, and received extra support from officers and clinicians when he needed it. However, she did not consider that staff took enough account of Mr Flynn's physical disability, which might have contributed to his vulnerability.

85. The clinical reviewer identified a number of additional matters in her clinical review about the organisation of the Pathways Unit including recording key worker sessions and staff training, which the Head of the Pathways Unit will need to address. We do not include these in this report, as the issues were not directly related to the circumstances of Mr Flynn's death.

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