FINAL REPORT

ARTICLE TWO COMPLIANT INVESTIGATION

IN THE CASE OF 'PL'

JULY 2024

COMMISSION AND TERMS OF REFERENCE

I am commissioned by the Secretary of State for Justice to conduct an investigation with the following terms of reference:

- to examine the circumstances of the incident on 29 July 2019 in which PL sustained a life-threatening injury, and, in so far as it is relevant, his management by HMP Stocken from the date of his reception on 7 March 2019 until that date, and in light of the policies and procedures applicable at the relevant time;

- to examine relevant health issues during the period spent in custody at HMP Stocken from 7 March 2019 until 29 July 2019, including mental health assessments and PL's clinical care up to the point of his life-threatening injury on 29 July 2019;

- to consider, within the operational context of HMPPS, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- to provide a draft and final report of my findings including the relevant supporting documents as annexes;

- to provide my views, as part of my draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State will take my views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the European Convention on Human Rights.

I have no authority to consider any question of civil or criminal liability.

The Interested Parties to the investigation are:

- PL, who has given his consent for the investigation to examine his healthcare records but has otherwise declined to take any part in the investigation.
- The Ministry of Justice, through Deputy Director, Safety and Workforce Transformation, Transforming Delivery Directorate, HM Prison and Probation Service
- Practice Plus Group, who provide healthcare at HMP Stocken
- NHS England who commission healthcare at HMP Stocken
- The Leicestershire Police Force
- East Midlands Ambulance Service NHS Trust who have assisted the investigation.

The investigators are:

Barbara Stow, Lead Investigator
Andy Barber, Assistant Investigator

Clinical advice has been provided by Facere Melius who commissioned the services of clinical specialists from several disciplines.

The procedure that the investigation has followed is attached as an appendix to the report. To protect his anonymity we have not used PL's correct initials, and we have not disclosed the names of members of staff and other witnesses. The names used for prisoners are pseudonyms.

Barbara Stow
BA (Hons), MSt (Cantab) Applied Criminology and Management

July 2024

EXECUTIVE SUMMARY

PL was found fitting and unresponsive in his cell at HMP Stocken in the afternoon of Monday 29 July 2019. He became unconscious. He was taken to hospital by ambulance. He was found to have a fracture to the skull and a bleed on the brain and he remained in an induced coma for some weeks. PL recovered and is able to live in the community independently but with some disabilities. It is not clear whether he is able to recall the events of 29 July.

The cause of PL's collapse was unknown. Two weeks earlier he had been found with visible injuries to the head and torso which were examined and treated in hospital, but he refused to say what had happened, and resumed daily life on the wing. After his collapse on 29 July, some prisoners gave information that PL had been assaulted earlier that day or at another time, and implicating a particular prisoner from the next-door cell, who had been the first to discover PL's collapse. One prisoner said that PL had been using 'spice' just before his collapse. There is no physiological evidence to confirm or refute this. Some officers reported after the event some circumstantial evidence that something had been amiss that morning and a possible altercation then, or two days earlier, but no officers witnessed an assault. The prisoner who was suspected of assaulting PL was segregated until he was transferred to another prison five weeks later.

A local enquiry was conducted by custodial managers at HMP Stocken. It reported on 7 August 2019 but was unable to discover the cause of PL's collapse or any conclusive evidence of an assault. A police investigation was inconclusive and was closed in October 2019.

In February 2020 a further management enquiry by the HMPPS Regional Safety Lead was also unable to establish the cause of PL's condition but obtained some additional information and made significant findings and recommendations.

Like those of our predecessors, our present investigation has been unable to discover the cause of PL's condition. We have found no significant additional evidence to establish whether he was assaulted on the day of his collapse or in the few days immediately before. The clinical advice to the investigation has concluded that PL's

brain injury was due to a physical injury, but that it was not possible to say whether this was from an assault or a fall. The clinical advisers concluded there was no evidence of a connection between the injuries to PL on 15 July and his condition on 29 July.

The central question of what caused PL to collapse remains unknown. But our investigation was also designed to examine broader questions about PL's care and management in prison. These include whether there were risks to PL that could have been foreseen, for example, medical indications that should have been identified earlier, or indications that PL was particularly vulnerable to violence on the wing, or that there was a level of disorder on the wing that should have been prevented by management. We have not found evidence of any specific shortcomings in the management and care of PL that are linked to his injury, but we hope that our opportunity to examine in detail events surrounding PL's life-changing injury may offer some helpful insights.

Issues to which we draw attention include views expressed by officers that suggest that they do not feel fully engaged in the Challenge Support and Intervention Plan process (a mandatory violence reduction case management system), and the way in which an influx of a large number of prisoners can cause volatility in a prison. Shortly before the events we have examined, Stocken had opened a new wing. We note that the Governor hoped to be able to take strategic preemptive measures when Stocken opens a new wing in 2024.

We make five recommendations about particular matters that came to our attention during the investigation. These are listed on pages 10 to 12 and are about:

Protocols for medication held by prisoners in possession

Liaison with the police during investigation of incidents in prison

Police access to healthcare records of a patient lacking capacity to consent

Communications with the ambulance service

Access for ambulances to the prison

The striking feature of our investigation was the frequency of prisoner on prisoner violence on PL's wing at the time, incidents that prisoners were generally unwilling to report for fear of reprisals. Stocken prison is not exceptional. We saw that staff and managers there were making strenuous efforts to reduce the prevalence of violence and Stocken stood well in comparison with similar prisons. But violence and the fear of violence are not conducive to reducing reoffending. The strapline of the Stocken safety strategy is that safety is the bedrock of a rehabilitative culture. We agree.

PL's offending history is associated with substance misuse dating back to his childhood. He has spent many years, first in youth custody, then in prison, often being recalled to prison for not complying with licence conditions. PL was not unwilling to engage in illicit activity in prison, including on one occasion violence. By doing so, he brought risks on himself, but it is regrettable that PL's long engagement with the criminal justice system has failed to divert him towards a happier life.

Throughout our investigation, we received patient and generous cooperation from HMP Stocken and the other Interested Parties. We were impressed by the thoughtful responses to our questions and the enthusiastic commitment that prison staff we interviewed showed for their work and the welfare of the prisoners. We had a sense of a staff united by a leadership they respected.

THE STRUCTURE OF THE REPORT

A full contents list is provided at pages 14 to 16 to help readers locate the issues we have examined. Broadly, the report is divided into three parts as follows:

Part One: PL's history and the events from 7 March to 29 July 2019

PL's history and his life on K wing, including healthcare, from reception to 15 July 2019.

The events of 15 July

Clinical care after PL's injuries on 15 July

Monday 29 July when PL was found unresponsive in his cell – the response to the emergency including clinical care

Further events on 29 July, including information received by staff.

Part Two: The investigations by the prison and the police: the enquiries after the event including the relationship with the police investigation.

The immediate investigation by the prison

The police investigation

The management enquiry in February 2020

Observations and conclusions from the prison's investigations and the arrangements for cooperation with the police

Part Three: Other issues emerging from the investigation.

Communications with the Ambulance Service

Conditions on K wing in July 2019

Tackling violence

Reports of the Independent Monitoring Board

What people told us about violence at Stocken

Most chapters end with a note of our observations and conclusions, but our observations and conclusions from the prison and police investigations are in Chapter 9.

An appendix to the report explains the procedure the investigation has followed.

The report uses pseudonyms to name some prisoners who were involved in significant events or whose names appear repeatedly as alleged victims or perpetrators of violence.

RECOMMENDATIONS

We make particular recommendations as follows:

Recommendation 1: Medication in possession

The default position in Prison Service and PPG policies is that prisoners, like patients in the community, should generally take responsibility for holding their medications in possession and taking them at the appropriate time as prescribed. But there are exceptions, depending on the nature of the medication and individual circumstances.

The Royal College of General Practitioners' Guidance on safer prescribing in prisons recommends caution in prescribing mirtazapine for patients with opioid addiction. PL was taking methadone. On 19 June, Dr Y agreed to prescribe mirtazapine at PL's request, but he was not allowed to have it in possession. It was to be issued under supervision and reviewed after a month (see paragraph 1.28 below).

On 17 July Dr Y renewed the prescription and, this time, PL was to be issued a week's supply at a time, to be held in possession. We have been unable to contact Dr Y to understand the reasoning for this decision. Dr Y has retired and is no longer registered as a doctor. We know of no evidence that PL misused or diverted his medication in the period between 17 and 29 July, but PPG policies, in line with good practice, require a risk assessment before medication is issued in possession. This was the more significant in this case as, on 26 June, PL had been seen diverting his mirtazapine, and his unexplained injuries on 15 July gave grounds to believe he was susceptible to bullying.

We recommend that the healthcare provider at HMP Stocken reviews the local practice on risk assessment for medication in possession to ensure that risk assessments are conducted as required. (Page 35)

Recommendation 2: Liaison with the police during investigation of incidents in prison

There were some difficulties in communications between the police and the prison which may have delayed the police investigation.

We recommend that the prison takes note of the problems that occurred in this case and ensures that where the police are investigating an incident in the prison, clear arrangements are made for a single point of contact in the prison and for another staff member to deputise if they are absent. (Page 66)

Recommendation 3: Police access to healthcare records

The police say that they were unable to obtain PL's healthcare records because the healthcare provider at the prison required his consent. PPG say they have no record of a request from the police but have commented, rightly, that they are bound by safeguards to protect the personal data of their patients, except in certain prescribed circumstances.

We recommend that PPG review their protocols for supplying data for the investigation of a suspected crime where the alleged victim has no capacity to give or withhold consent. Any request to disclose information to the police should be recorded, with a note of the reasons for the decision to disclose or to refuse disclosure. (Page 68)

Recommendation 4: Communications with the ambulance service

We have learned that each Ambulance Trust adopts its own emergency dispatch protocols. It is notable that EMAS routinely uses the prison's attribution of Code Red or Code Blue to allocate the degree of priority to an emergency call. This is contrary to the assumption and the advice in PSI 03/2013, but it is a practical response to the fact that a 999 caller from a prison is unlikely to be with the patient and consequently not able to give accurate answers to the standard triaging questions in the internationally recognised Advanced Medical Priority Dispatch System (AMPDS).

The clinical review to the investigation has advised that the symptoms/conditions listed in the HM Prison guidance for Code Blue and Code Red calls can, due to the way Ambulance triage systems work, attract different call categories. EMAS indicates that a lack of information in emergency calls from a prison might result in an inappropriately low priority being allocated if they were to rely solely on the triaging questions in AMPDS.

Recent amendments to HMPPS national and local protocols recognise the importance of providing all relevant information to the emergency service, as the priority given to the call will depend upon it. But it is characteristic of medical emergencies in prison that the member of staff who speaks to the ambulance service is unlikely to be with the patient so is passing on information second-hand. There may be technological solutions which would enable a staff member who is with the patient to speak directly to the emergency service, but we are not aware of any such systems in use at present.

We recommend that the Governor of Stocken (locally) and HMPPS (nationally) review the present arrangements for communications with the ambulance services to examine whether current policy and practice appropriately reflects the ambulance services' system of allocating priorities. (Page 78).

Recommendation 5: Access for ambulances to the prison

It took some 12 minutes after arrival at the Main Gate for the ambulance crew to reach PL. It is not clear whether staff were primed to facilitate access for the ambulance.

We invite the Governor to examine whether the 12 minutes from arrival at the prison to attending a patient on K wing is unavoidable or whether the process of accessing the wings in emergencies can be made more efficient. (Page 78)

THE REQUIREMENT FOR PUBLIC SCRUTINY

My commission required me to provide my views, as part of the draft report, on what I considered to be an appropriate element of public scrutiny in all the circumstances of the case.

My objectives for the investigation have been:

- to bring to light as far as possible, all the relevant facts
- to discover any shortcomings that might have adversely affected PL's care
- to draw from what happened any lessons that might help to reduce risks to others in future.

The investigation team obtained documentary material from HMP Stocken, including confidential security information. We visited the prison, we interviewed 11 members of staff, a representative of the Prison Officers' Association, the Chair of the Independent Monitoring Board and two prisoners. The Leicestershire police have shared with us full details of their investigation. We have seen records from the East Midlands Ambulance Service NHS Trust. Clinical advisers have had access to hospital records. Through his then probation officer, PL gave his consent for disclosure of medical records, but he has taken no further part in the investigation, and we are not in touch with him. We made arrangements on two occasions to meet PL but on neither occasion did he attend, and he has not responded to communications since then.

The investigation leaves questions we cannot answer. As PL has declined to take part in the investigation, we do not know what account he would give of his experience in prison. However, I have no reason to believe that any further significant information could be discovered through any fresh process.

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PART ONE

PL'S HISTORY AND THE EVENTS FROM 7 MARCH TO 29 JULY 2019

CHAPTER ONE: PL's HISTORY AND THE PERIOD AT HMP STOCKEN FROM RECEPTION TO 15 JULY 2019

PL's history

1.1 In 2019 PL was 27 years old. He had a prolific offending history dating from the age of 11 when, by his own account, he was introduced to, first, cannabis, then heroin and crack cocaine, by adult members of his family. PL spent periods in youth custody then in prison, for offences of battery, robbery and possession of Class A and Class B drugs.

HMP Nottingham

1.2 In August 2019, PL was remanded to HMP Nottingham on a charge of robbery. His behaviour there was erratic. He was located on the Byron wing, which I understand is a special unit to manage complex cases through the Challenge, Support and Intervention (CSIP) scheme.[1] Sometimes he engaged enthusiastically with the activities offered there. At other times he was abusive and uncooperative, on occasion smashing furniture, barricading his cell and threatening staff. At times he was suspected or known to have been using drugs. In February 2020, he was placed in segregation after a seemingly random assault on another prisoner. He was transferred to Stocken prison on 7 March.

At HMP Stocken

1.3 On arrival at Stocken prison, PL told an officer he believed he was at risk from two prisoners from whom he had borrowed vapes at Nottingham. The officer completed a referral form for investigation under the Challenge, Support and Intervention Plan

[1] The CSIP scheme is a mandatory violence reduction case management model that must be used across the adult prison estate. See below, paragraphs 12.13 to 12.25.

scheme (CSIP). The risk was considered according to CSIP procedures and it was agreed it could be managed on the wing. The two prisoners concerned were on a different wing. The CSIP report says that PL was happy to move to K wing but wanted staff to be aware.

Induction

1.4 During induction, PL is said to have engaged well with the chaplain and to be keen to take part in chaplaincy activities. He wanted to light a candle on 1 July to mark the anniversary of his mother's death.

1.5 He is also said to have engaged well in an interview with the induction wing supervising officer (SO), who noted that PL was to be referred for counselling having lost his mother the previous year and had no support with this. PL seems to have been reluctant to leave the induction wing but said he was willing to move but not to share a cell. It was agreed that he would not move immediately but the SO said that if he did not move when required he would be put down to Basic regime. PL said that the television was his comfort and if he lost that he would have nothing to lose. The SO took this to mean he would be disruptive.

1.6 PL was introduced to his offender supervisor, who found him motivated and positive. She referred him to education for Course CFO3, which focused on offenders who have difficulty accessing mainstream employability or training services. An instructor from the education trust emailed the offender supervisor to say that PL was keen to go to a rehabilitation facility but wanted to be out of Nottingham. PL expressed a wish to engage in restorative justice, but his victim was unwilling.

Healthcare and substance misuse treatment

1.7 Healthcare at Stocken was commissioned by NHS England and provided by Practice Plus Group (PPG - formerly Care UK). PPG, in turn, subcontracted psychosocial

substance misuse services to Inclusion, as part of the Integrated Substance Misuse Treatment Service. PPG provided clinical treatment for substance misuse.

1.8 An '*Integrated Drug Treatment System – IDTS*' was introduced in 2014 as a joint service of the Home Office, Department of Health, the Ministry of Justice and the Prison and Probation Service. It aimed to increase the volume and quality of care of substance misuse treatment, with particular emphasis on: early custody, improving the integration between psychosocial and clinical services, and reinforcing continuity of care between prisons and community settings. From April 2018 the service specification for substance misuse treatment services commissioned by NHS England is for '*Integrated Substance Misuse Treatment Service'.*

Healthcare assessments

1.9 At Nottingham, PL was taking prescribed methadone (20mls daily) and 90mg slow release dihydrochloride (DHC - an opiate painkiller) for back pain.

1.10 On admission to Stocken on 7 March, PL received an initial health screening which was in accordance with NICE (National Institute for Clinical Excellence) and NHS guidelines. He was assessed for whether he should hold medications in possession and it was concluded he would be allowed seven days' supply of DHC. However, the prescription for DHC had not been forwarded from Nottingham so he did not receive this. An initial plan was made to see a GP, who prescribed 20 mls methadone, and PL was referred to the substance misuse service and mental health. On 11 March he received a secondary health screen where he was offered appropriate screening and vaccination and DHC was prescribed.

1.11 On 12 March, PL attended a drug treatment assessment interview. He described his history of drug use from childhood, using cannabis from the age of 11, then heroin and crack cocaine. He told the assessor he continued to use drugs except when he was in prison, where he received methadone. He said he was drug-free for three months after being released from prison in April 2018 until his mother suddenly died in July

2018 and he was left homeless with only his aunt for support. He said he used drugs to take away his thoughts and feelings about his mother and that was why he had relapsed. He said later that at this point he started to inject heroin though he had previously smoked it. He said he wanted to learn to cope without drugs and to be clean and clear-headed and was said to be keen to be referred to a counselling service. A care plan was opened with detox from methadone as the goal.

1.12 From 12 to 19 March, PL appears to have missed several healthcare appointments. This delayed restoration of his DHC until 21 March. He was angry about this but claimed to be highly motivated to reduce his methadone dose and to be able to move to I wing (the recovery wing).

On K wing

1.13 PL was initially reluctant to move off the induction wing and said he was unwilling to share a cell, but he subsequently did so. K wing is a drug dependency wing with a dispensary for administering methadone. The wing is L shaped and on two levels. It houses 128 prisoners in 120 cells, 12 of which are shared. There are 30 cells on each level on each spur.

1.14 Shortly after moving to K wing, PL again confided to an officer that he believed he was at risk. He said his cellmate had told him to watch his back. According to the CSIP investigation dated 23 March, PL did not name any prisoners but said he believed he was under threat from seven or eight people on K wing South spurs who were possibly after him, but he would not say what the issue was or identify the people he believed to be involved. He said he wanted to go to work and have a wing move and he declined a victim support plan. The officer's note says he told PL he needed a steady period of good behaviour first, then staff could look at other options. He advised PL to tell staff if he had further concerns, or to contact Safer Custody.

1.15 The officer recommended that the issue could be managed on the wing and asked for the wing manager and staff to monitor PL's movements. Managers were asked to confirm the recommendation and it was resolved to manage it on the wing.

1.16 According to the records, PL's behaviour and demeanour continued to be variable over the following months. Notable events were as follows:

March 2019

1.17 On 26 March, PL was believed to have removed a stapler from the college and taken it back to the wing. He refused a full search. His cell, which he shared with a cellmate, was searched. A homemade pipe and green leafy substance were found and PL was placed on closed visits for one month.

1.18 PL told his drugs worker he had told wing staff that other prisoners had warned him he was under threat on K wing. He claimed that consequently he was 'virtually self-isolating'. He said he wanted to get to I wing (the drug recovery wing).

April 2019

1.19 There were some instances of suspicious behaviour and minor infractions during the month. PL received an IEP warning for giving a false excuse to be allowed to leave college. He resented that his prison pay was being taken for the damage he had caused to cells at Nottingham. He removed paper from the college and it was suspected this was linked to distributing drugs.

1.20 Case notes record cordial but seemingly superficial conversations with his keyworker.

1.21 On 16 April, PL had an initial mental health assessment. PL was now on 10mls methadone. He wanted an antidepressant and was advised to submit a GP application. He had no acute mental health problems but said he was struggling with grief and loss from his mother's death. He preferred to be treated by the medical

model and declined psychosocial interventions. He was advised to see his GP for antidepressant prescribing and discharged from secondary mental health services. This was in accordance with NICE clinical guidelines and Practice Plus Group's standard operating procedure.

1.22 At times, PL expressed a wish to reduce his methadone to the point where he was no longer dependent and could move to I wing, the recovery wing. At other times he dismissed the idea.

May 2019

1.23 In the course of the month, PL started employment in a workshop but he was not interested and wanted to go back to the college. There was a waiting list for education, and he became bored with being unemployed and said he was willing to take any job.

1.24 PL saw GP, Dr Y, who noted no self-harm or suicidal ideation and prescribed Fluoxetine for depression for one month. The GP noted that PL said he was low at times, especially at night, but showed no signs of depression at the appointment. An appointment was scheduled for a review after one month.

1.25 At a one-to-one meeting with his drugs worker, PL stated he was using spice when it was available. He said he knew the risk of dying but the enjoyment currently outweighed the risk. He would continue to reduce his dose of methadone gradually.

June 2019

1.26 An apparent debt list was recovered in a cell search on another wing. It appears to refer to debts owing for illicit drugs. It lists the names, nicknames or locations for some 20 prisoners. The sum of £450 is listed against a K wing prisoner with PL's first name. A security report was raised.

1.27 Entries in case notes in June by PL's key worker, Officer A, say he had been allocated a work placement that he seemed to enjoy; he said everything was OK; he was taking part in substance misuse treatment and was pleased to have moved to a single cell.

1.28 On 19 June, PL told Dr Y he found no benefit from Fluoxetine and wanted to switch to mirtazapine, which is a medication for major depression. The Royal College of General Practitioners' Guidance on safer prescribing in prisons recommends caution in prescribing mirtazapine for patients with opioid addiction. PL was taking methadone. Dr Y prescribed mirtazapine for one month, but made a note expressing concern that PL had asked for mirtazapine specifically so he was not to hold the tablets in possession. This would be reviewed after the first month.

1.29 Medical records say that on 26 June PL attempted to conceal and divert mirtazapine. Case notes say he was given an IEP warning for diverting his medication at the Pharmacy hatch. He was suspected of being involved in trading drugs. Healthcare sent a standard warning letter to PL regarding his actions.

July 2019

1.30 On 2 July, PL told his drugs worker his methadone reduction was going well, he had been accepted for one-to-one counselling and for Resolve, to start in August.

1.31 Case notes say that on 5 July the key worker spoke with PL about recent case note entries, then at his request chased up his application to convert visiting orders to PIN phone credits.

What staff told us about their impressions of PL on K wing

1.32 We asked PL's key worker, two current and one former officer about their impressions of PL. A number of other members of staff who had worked on K wing at the time had left the prison service and we were unable to interview them.

1.33 Officer A, who was PL's key worker, described PL as cheeky. He would have a bit of a laugh. If he had a negative report, he would make light of it, saying staff had taken a joke too seriously. She had aimed to tutor him in appropriate behaviour for the community and the workplace. He usually only wanted to talk about exchanging his visiting orders for phone credits. He tended to keep the sessions short. He didn't speak much and sometimes seemed like a teenager who couldn't be bothered to get out of bed. He never raised any issue about bullying.

1.34 Officer B said he knew PL by his first name. He was the same as any other prisoner and he was not aware of any issues. In a statement, Officer B described PL as an 'under the radar' prisoner.

1.35 Officer C said he knew PL on the wing but was not aware until 29 July that he had been involved in any incidents. He did not know PL had been found to be diverting medication.

1.36 Both officers said they had not thought of PL as either a bully or a victim.

1.37 Officer D no longer worked at Stocken but had a detailed memory of prisoners and events on K wing. She said PL was not a 'loud' prisoner. He kept himself to himself and preferred to deal with things himself or with his peers rather than approaching staff. She had not been aware that PL had been seen to divert medication, but her impression was that he was easily bullied, and she was not surprised if he had been influenced to do that. She saw him as a victim rather than a bully and commented that the prisoners reliant on methadone were easily targeted by stronger characters on the wing.

Observations and conclusions

1.38 On the two occasions that PL told staff that he believed he was at risk from other prisoners, CSIP referrals were made in accordance with required procedure. Available information was considered, and it was decided that no action was required except to

monitor PL on the wing. We say more about the CSIP system in Chapters 12 and 14, but, given the very limited information that PL was able or willing to disclose, we would not have expected any other conclusion.

1.39 The Substance Misuse Treatment Service provided by PPG was PL's main contact with healthcare at Stocken. He was seen weekly or fortnightly for 1:1 sessions with his substance misuse worker. These sessions involved reviewing care plans, assessing for any withdrawal symptoms, harm minimisation advice, risk assessment and considering options for rehab on release. PL also had regular formal reviews with the prescribing GP, and his mental health care was primarily undertaken and managed by the GP.

1.40 Informed by the clinical review conducted for my investigation, I am satisfied that PL's clinical care during this period was consistent with NICE and NHS guidelines and with Practice Plus Group's policies.

CHAPTER 2 - EVENTS ON 15 JULY

2.1 Checking the roll at about 1800 on Monday 15 July, Officer D was alerted by a prisoner that two prisoners had been assaulted, that one had been beaten and that PL had been stabbed.

Injuries to PL

2.2 Officer D's entry in the observation book says that PL had multiple injuries mainly to his face and head. The officer examined PL's injuries with two other members of staff. The examination is recorded on a body-worn video camera at 19:12.

2.3 The video footage shows: a triangular area of swelling and a small abrasion above PL's right eye, an inflamed area toward his right ear beneath the right cheekbone, an inflamed scratch at the base of his neck, an open wound to the back of his right ear; an inflamed area of swelling and abrasions to the left side of his forehead to the hairline, further bruising behind his left ear and a cut inside the ear, a scratch to his left forearm, bruising to the right forearm, hand marks on the right side of his back and further bruising to the top of his back.

2.4 PL was taken out on escort to hospital where he received seven to eight sutures behind his right ear and was discharged back to prison with antibiotics and paracetamol. He returned to the wing at 03:15 the next morning.

2.5 A CSIP investigation was opened.[1] Officer G interviewed PL at about 08:40. His note says PL refused to give any information about how, when or where he received the injuries. Officer G reported that PL appeared relaxed and in a good mood, that he said he felt safe on the wing and did not expect any further repercussions. It was

[1] Challenge Support and Intervention Plan. The CSIP scheme is a mandatory violence reduction case management model that must be used across the adult prison estate. See below paragraphs 12.13 to 12.25.

concluded that, as PL refused to give any information, no further action could or would be taken.

Injuries to Prisoner York

2.6 The other prisoner named to Officer D as having been assaulted on 15 July was Prisoner York. Officer D recorded in the wing observation book that Mr York was seen to have facial injuries.

2.7 Officer D checked the CCTV, which showed Prisoner Bedford entering a cell at 17:41. (It was Prisoner Bedford who subsequently alerted Officer D.) Mr York went to the cell door. Prisoner Durham pushed him into the cell. Prisoners Norfolk and Chester entered. Prisoners Cornwall and Bexley stayed at the door.

2.8 Officer D recorded that she spoke to Mr York, who claimed he fell over. The incident was referred for investigation under the CSIP system and entered in a security report.

2.9 The observation book contains an additional entry about the injuries to Mr York. An entry at 20:10 on 15 July, just before handover to the night staff says that an officer (signature not legible) heard shouting from the 1s and 2s and stood by the shower to listen. The officer heard Prisoners Durham, Redbridge, Chester and Devon shouting at Mr York, saying, *'What did you tell the screws?*' Mr York replied, '*Nothing. I just told them I slipped in the showers.*' Mr Durham replied,*' You better or get [illegible] it tomorrow.'*

2.10 Mr York was interviewed the next morning. The record says he refused to be interviewed in an office, saying he had slipped in his mate's cell and banged his head, that he had not been assaulted, that he did not need healthcare and that everything was 'okay'. The decision was that no further action would be taken but that wing staff should monitor.

Alleged assault on Prisoner Camden

2.11 An entry in the observation book in the morning of 16 July, says that Prisoner Camden told an officer (signature illegible] that the previous day at about 1730-1800 he was asked to go to Cell 46 where he was grossly assaulted by Prisoners Devon, Suffolk, Chester and Stafford, allegedly because he was said to have secreted a mobile phone.

Information about the incidents

2.12 Information was received from a prisoner in the afternoon of 16 July that the assaults were due to PL selling hooch (illicit fermented liquid) he was holding. It was stated that a group of prisoners were intimidating others and that it appeared the staff were doing nothing about it. The assessment of the information accepts the explanation as the probable reason for the assault on PL.

2.13 The information received named the main culprits as Prisoners Devon, Durham, Norfolk and Cornwall, with Mr Norfolk and Mr Durham as the main players. It was said that on the evening of the assault they were all 'pissed', and barging into people, purposely trying to pick a fight.

2.14 They were said to be getting people into debt, sometimes for as little as a vape, then making them do or hold things as payback. Also, paper falsely purporting to have spice was being sold to vulnerable or indebted prisoners and being passed off as spice. Information known previously about the prisoners concerned was consistent with the information received. All had histories of involvement with drugs, bullying, threats and violence.

2.15 Another prisoner told an ACCT assessment on 16 July he had self-harmed mainly because of constant bullying by Mr Norfolk and Mr Devon. [1]

[1] ACCT is Assessment, Care in Custody and Teamwork –a set of policies to identify and safeguard prisoners at risk of suicide and self-harm

2.16 On 18 July a pungent orange smell was detected from PL's cell. Hooch 'kicker' was found under his bed, and he was put on report.

2.17 PL's key worker's case note on 22 July says she asked PL about his injuries and he told her he *'got rushed'* but did not give much detail as '*wing staff already know'*. He was apparently unemployed again and bored in his cell but there was a long waiting list for employment. The keyworker's entry for 28 July says PL was allocated a new job in a workshop and though not enthusiastic he was pleased he would not be stuck behind his door. They had a general chat about how he was doing OK.

Action following the three suspected assaults

2.18 The account of events above is taken from entries in the wing observation book and from intelligence reports that officers submitted. Officer D reported the injuries sustained by PL and Mr York. Prisoner Bedford, who alerted Officer D, was known to have been a victim of bullying. Mr York and PL both had histories of involvement in unlawful activities but also as victims of bullying. The security assessment was that both prisoners had been assaulted by unknown perpetrators and the incident indicated a possible threat of disorder.

2.19 I have not seen the security report relating to the entry in the wing observation book about verbal threats to Mr York the following morning.

2.20 The injuries to PL and Mr York were both reported in the daily incident report the next morning. The report concluded that as the victims refused to give information no further action would be taken but wing staff were to monitor. The report makes no reference to the CCTV footage showing Mr York entering a cell shortly before the assault or the threats to him that were overheard later (see paragraphs 2.5 and 2.7 above).

2.21 I have not seen the security report about the alleged assault on Prisoner Camden.

What staff told us

2.22 Custodial Manager H (CM H) signed off the CSIP investigation into PL's injuries. CM H was not based on K wing at the time. He received the report of the CSIP investigation but did not speak to PL himself. As PL was not disclosing anything and did not want any further action CM H signed the investigation off. From memory, he thought he had asked for PL to be seen at a later date by Safer Custody to see if he required any support or would disclose anything. We have not seen any record of this.

2.23 Officer D said she was shocked at the extent of injuries around PL's face. Generally, an assault would be to the torso where it would be less conspicuous. From the position of the injuries, she suspected there was more than one assailant, and she named prisoners whom she thought might have been responsible.

2.24 Officer B was not on duty on 15 July. When he next saw PL, he noticed his black eye and PL showed him the wound to his ear. The officer did not recall any discussion with colleagues about the incident. He told us that K wing was a drug dependency wing, with many prisoners in debt for drugs and unwilling to explain anything. They didn't want to be 'grasses' or 'snitches' but would just 'get on with it'.

2.25 PL's key worker saw him next on 22 July. She told us she asked him about his injuries, but he said he didn't want to talk about it, that staff knew already, and everything was all right, so she didn't pry. She believed she had spoken to wing staff who said that a CSIP had been raised.

Observations and conclusions

2.26 It is evident from our investigation that, on the whole, staff were conscientious in recording information about the incidents in the wing log, making security reports and referring them for consideration through the CSIP system. However, it is not clear that the additional information from CCTV footage and overheard threats to Mr York were linked with the initial reports.

2.27 Where CSIPs were closed for lack of substantial information there is reference to an expectation that wing staff would monitor. It is not clear to us what this amounted to in practice.

2.28 In Chapter 12 we examine the CSIP system and the other measures that Stocken has in place to try to reduce the prevalence of violence in the prison.

CHAPTER 3 - CLINICAL CARE TO PL AFTER HIS INJURIES ON 15 JULY

3.1 The clinical advisers to the investigation have examined PL's medical records. They have advised me about the assessment and treatment he received in the hospital emergency department and his clinical care in the period from 16 to 29 July when he returned to the prison.

At the Emergency Department

3.2 PL's records from the Emergency Department at Peterborough Hospital show that he sustained an injury behind his right ear after an assumed assault. His clinical summary states that he looks generally well and that the laceration behind his right ear needed suturing. The summary also states that he has been punched several times and had a small laceration to the back of his head, thought to have possibly been caused by a key, and swelling above the right eyebrow. PL was reviewed by the Ear Nose and Throat Senior House Officer in the Emergency Department, who agreed that the wound required suturing, and that following this PL could be discharged with antibiotics. The sutures were to be removed in seven days in HMP Stocken. Observations recorded at 21:23 were within normal parameters, with a pain score of 0 and his AVPU (Alert, Voice, Pain, Unresponsive) assessment was 'alert'. Following suturing, his treatment was considered to be completed and PL was discharged back to the care of HMP Stocken with no follow-up required from the hospital.

3.3 I am advised that there is no evidence during this attendance at the Emergency Department that PL had suffered a significant head injury that required further observation or diagnostic tests such as a CT scan. PL was not complaining of nausea, headaches or change in vision. In the opinion of my clinical advisers, there was no indication that a scan was required. In line with NICE Guidelines (CG176), it is normal practice for patients deemed fit for discharge to be discharged to their usual place of residence, which in PL's case was HMP Stocken. As there was no clinical reason for him to remain in the care of the acute trust, he was discharged, with the expectation that he would be followed up by the prison's health professionals.

3.4 The clinical review team to the investigation advises that the care and treatment provided to PL was commensurate with his presentation and symptoms. On presenting at the Emergency Department, he would have been treated as having a simple head injury, he would have been advised about what to look out for within the next 24/48 hours and he would have been discharged. This is noted in the discharge summary as 'seek advice in case of any concerns.' This would have been the same treatment irrespective of whether he presented from prison or the community, or the mechanism of his injury, that is whether it was from a collapse, a fall or an assault.

PL's clinical care: 16 to 29 July 2019

3.5 The healthcare record notes that PL was discharged from the Emergency Department into the care of the prison. During the period, 16 to 29 July 2019, he was seen frequently by healthcare professionals at HMP Stocken, where the team included medical and nursing staff.

3.6 On 17 July PL was seen by GP, Dr Y, and wound care advice given. He is said to be *'well and smiling*'. It is noted he was happy on mirtazapine and to change to *'weekly in possession'*.

3.7 On 23 July the sutures were removed as planned. The wound behind his ear is said to be clean and healed.

3.8 On 24 July PL saw his drugs worker. Her note says he presented well and calmly and was able to engage in chat about his recent assault and injury to his ear. He said he was OK on the wing, his methadone reduction was going according to plan, and there were no issues.

3.9 On the 25 July he attended clinic for a hepatitis B vaccination, and he is noted as being 'well'.

3.10 Nothing is noted or flagged that would indicate any concerns regarding an ongoing or evolving head injury following the assault on 15 July, i.e., no change in vision, nausea, or headaches. Nothing is noted other than the date and time of his reviews from 25 July to 29 July when he is found having a seizure on the floor of his prison cell.

Observations and conclusions

3.11 I am advised by the investigation's clinical review team that there is nothing in PL's prison healthcare record to suggest that staff had any concerns about him in relation to the injury sustained on 15 July 2019. He was not complaining of headaches. He was able to communicate with staff, and he had no changes in behaviour, cognitive ability or vision that might have caused concern. On his return to hospital on 29 July the wound behind his right ear is described as healed.

3.12 The default position in Prison Service and PPG policies is that prisoners, like patients in the community, should generally take responsibility for holding their medications in possession and taking them at the appropriate time as prescribed. But there are exceptions, depending on the nature of the medication and individual circumstances. As we noted above (paragraph 1.28), the Royal College of General Practitioners' Guidance on safer prescribing in prisons recommends caution in prescribing mirtazapine for patients with opioid addiction. PL was taking methadone. On 19 June, Dr Y had agreed to prescribe mirtazapine at PL's request, but he was not allowed to have it in possession. It was to be issued under supervision and reviewed after a month. On 17 July Dr Y renewed PL's prescription for mirtazapine and, this time, PL was to be issued a week's supply at a time, to be held in possession.

3.13 Dr Y has retired and is no longer registered as a doctor. We have been unable to contact Dr Y to understand the reasoning for deciding PL could safely hold the medication in possession. We know of no evidence that PL misused or diverted his medication in the period between 17 and 29 July, but PPG policies, in line with good practice, require a risk assessment before medication is issued in possession. This was the more significant in this case as, on 26 June, PL had been seen diverting his

mirtazapine, and his unexplained injuries on 15 July gave grounds to believe he was susceptible to bullying.

We recommend that the healthcare provider at HMP Stocken reviews the local practice on risk assessment for medication in possession to ensure that risk assessments are conducted as required.

CHAPTER 4 - MONDAY 29 JULY - PL IS FOUND UNRESPONSIVE IN HIS CELL

4.1 On Monday morning 29 July, PL refused his methadone. We do not know why.

4.2 After lunchtime on Monday 29 July, Officer J unlocked the cells on the 1s level on K wing. He did not look through the observation panel into PL's cell. Officer J told the police this was because he was distracted by a cell bell and shouting further down the landing. A few minutes later, prisoners at the cell pressed alarms to alert officers. Officer J was first to arrive at the cell, quickly followed by others. He called emergency Code Blue by radio.[1] The Communications operator called an ambulance at 14:02 and alerted Hotel 1, Oscar 1 and Victor1. (Healthcare, Duty Manager and Duty Governor).

4.3 In his statement for the police, Officer J says PL was on the floor to the right of the bed, on his back, having a fit, with his feet toward the door and arms bent around his head. He was shaking but not violently. His trousers were wet and there was corresponding wetness on the bed and the pillow. There were no other prisoners inside the cell. Officer J cleared the area around PL so he could fit safely. He thought PL might have fallen off the bed while fitting. He could see bruising around PL's eyes and cheeks but nothing obviously fresh. He could not see the back of his head.

4.4 Nurses from Healthcare arrived within a few minutes. Prison GP, Dr Y, also attended. The ambulance crew arrived at the prison at 15:05 and at PL's cell at 15:17. They suspected a bleed on the brain. PL was transferred to Peterborough General Hospital. He had not regained consciousness. A CT scan showed a large extradural haematoma[2]

[1] Code Blue is the prison service's internal emergency call for patients suffering chest pain, difficulty in breathing, unconscious, choking, fitting or concussed, a severe allergic reaction or a suspected stroke. We say more about this in Chapter 10.

[2] Clinical reviewers advise: a haematoma is a localized swelling filled with blood caused by a break in the wall of a blood vessel. The breakage may be spontaneous, as in the case of an aneurysm, or caused by trauma. The blood is usually clotted or partially clotted, and exists within an organ or in a soft tissue space such as muscle. Treatment depends on the location and size of the haematoma but usually involves draining the accumulated blood. A haematoma in or near the brain is particularly dangerous.

on the right side of his head. Neurological opinion was requested, and he was transferred to Addenbrookes Emergency Department for neurological care.

Clinical care – 29 July

4.5 Three nurses attended PL. One of the nurses was already on the wing when the alarm sounded. Her entry in SystmOne says PL was lying fitting on the floor. He was placed in the recovery position. His jaw was clamped. An airway was inserted with difficulty.

4.6 Dr Y attended PL at 14:20, joining the nurses. There was no smell suggestive of smoking an illicit substance. There was a packet of seven days mirtazapine and one paracetamol left in a strip. There was no evidence of illicit drugs. Dr Y's entry describes PL's condition and appearance, including a swelling to the right temple. His pupils were fixed, with the right pupil more dilated than the left.

4.7 Entries in SystmOne gives full details of PL's condition and the measures taken by healthcare staff. The nurses attended with emergency bags and commenced immediate life support. PL was noted to be unconscious and given oxygen. His airway was protected using a nasopharyngeal airway.

4.8 Throughout the period from when prison staff attended and the ambulance crew arrived, PL's vital signs were monitored. He maintained recorded saturations of >96%, so with oxygen being administered his oxygen saturation was maintained within the normal range of 95% to 100%. He was administered diazepam as a first line treatment to halt the seizures.

An extradural haematoma is a collection of blood in the 'potential' space between the skull and the outer protective lining that covers the brain (the dura mater). It usually occurs because of a head injury. It is a serious condition and emergency treatment is needed. An operation to remove the haematoma may be required.

4.9 The ambulance crew reached PL at 15:17. A prison doctor and nurses were with PL. The ambulance staff rated him at GCS3[1], that is, the lowest state of consciousness on this scale.

4.10 In her statement for the police investigation Ambulance Technician 1 (AT1) says she noticed red marks on PL's knuckles and bruising round one eye. One of the officers said that PL's ear had been stitched in hospital after his head had been *'stamped on'* the week before, and this seemed to fit with the injuries to his hand and eye, which both looked like old injuries. There was some dried blood from his nostril which AT1 thought was probably from insertion of the airway. She did not recall noticing any other injuries. From what people were saying, it seemed he might have fallen from the bed to the floor while having a seizure, but the mechanism of the fall was not clear.

4.11 Ambulance Technician 2 (AT2) says that when they arrived at the cell, PL's breathing with the aid of a nasal airway was very noisy, that is *'stridor'* breathing, and they inserted in addition an oral pharyngeal airway so he could breathe through his mouth. The prison doctor said that PL's pupils were unequal, which suggested a neurological issue such as a head injury or a bleed on the brain, but there was nothing AT2 could see during her examination and observation of him that shed any light on the cause of his condition.

4.12 AT2 says the ambulance crew left the prison at 16:30. A prison officer accompanied PL in the ambulance attached to him by a long chain. Another officer travelled in the front of the vehicle. At no point did PL regain consciousness. They arrived at Peterborough General Hospital at 16:55, handing PL's care to the Emergency Department at 16:58. At the hospital PL went straight into Resus.

[1] Clinical reviewers advise: The Glasgow Coma Score (GCS) is used to assess the level of consciousness after injury. It measures response to stimuli in three main areas - eye, movement and verbal. The quality of each response is 'scored', giving a final score on a scale of 3 to 15 across all three areas. So, for example, a score of 15/15 would indicate a patient who is fully alert and responsive, whereas a score of 3/15 would indicate that the patient is totally unresponsive.

The hospital records

4.13 On arrival at Peterborough City Hospital Emergency Department, PL's history was taken. It is noted that he has not regained consciousness since 14:00 that day, on assessment his GCS was 4, with pupils unequal and unreactive. Observations were undertaken half-hourly. He was intubated at 17:17 and a CT (computerized tomography) scan was undertaken. This showed a very large extradural haematoma on the right side. PL was sedated and maintained in a medically induced coma. At 19:50 he was transferred to Addenbrookes Hospital. A neurological opinion was requested. PL left Peterborough at 19:55 and he was transferred to Addenbrookes ED for neurosurgical care, arriving at 20:40.

4.14 The discharge note from the Emergency Department says, 'Not known to have taken any illicit drugs today'. There is no reference in the discharge note to any urinalysis being undertaken. There is reference to blood tests, but these would not indicate the presence of illicit drugs which are picked up through urine tests.

Clinical advice to the investigation

4.15 Clinical advisers to my investigation have had access to hospital records, including X-rays. They conclude that the very large extradural haematoma identified on the X-ray of 29 July 2019 is the result of a physical injury, but that it is not possible to say whether this is from an assault or a fall.

4.16 They conclude that the time elapsed between the injuries sustained on 15 July and PL's condition on 29 July is too long to indicate a connection. The review states that it is not possible to conclude categorically that the two events are not connected, as any assault or knock will lead to an area of vulnerability, but the likelihood is that what PL presented with on 29 July happened on or around that date.

Observations and conclusions

4.17 Informed by the analysis and findings of my clinical advisers, I am satisfied that, once the alarm was raised by prisoners, the response by the prison and healthcare staff who attended PL on the wing was timely, skilled and appropriate. PL's vital signs were monitored, and the principles of assessment and resuscitation were applied. Appropriately skilled staff were in attendance and 999 calls were made for assistance.

4.18 The officer who unlocked PL's cell did not look through the door window. An internal inquiry conducted shortly after these events recommended that officers unlocking cells should take note of the condition of the prisoner. That is clearly good practice.

4.19 The ambulance arrived at the prison some 63 minutes after the first 999 call and the ambulance crew were with the patient 12 minutes later. I have some concerns about the communications between the prison and the ambulance service and the arrangements for access to the prison. This is explained in Chapter 10.

4.20 The clinical advisers conclude that PL's condition was the result of a physical injury, but they cannot say whether this was caused by an assault or a fall. They found no evidence indicating a correlation between PL's condition on 29 July and the injuries he suffered two weeks earlier.

4.21 There is no material evidence that PL had taken any illicit drugs on 29 July, but no tests were taken by the hospital that would confirm or refute this.

CHAPTER 5 - FURTHER EVENTS ON 29 JULY

Reports after the event

5.1 The cause of PL's collapse was not known at the time. He refused his methadone that morning. We do not know why. Learning of PL's collapse, another prisoner told an instructor PL had been smoking spice at lunchtime. Prisoner Mr Redbridge referred in his interview with the police under caution to PL being *'high'* that morning.

5.2 I am not aware of any substantial evidence to support or to rebut the suggestion that PL was under the influence of drugs when he collapsed. An entry in SystmOne says Dr Y saw no evidence of drug-taking in PL's cell. The police examination of the cell reported the presence of a pipe but no evidence of drugs. No clinical tests were carried out by the hospital that would show the presence or absence of illicit substances. There is no indication that the prisoner who reported that PL was smoking 'spice' at lunchtime was questioned further.

5.3 There was initially some suspicion that Mr Redbridge and possibly his cellmate Mr Durham had assaulted PL in his cell just before the alarm was raised. Subsequent viewing of CCTV footage indicated that this was most unlikely as they were at the cell only very briefly before they were joined by others and the cell and general alarm bells were pressed. Interviewed by his key worker and later the police, Mr Redbridge said he was alerted by sounds of banging from PL's cell, and his description of PL on the floor, apparently having a seizure, corresponds with that given by the officer who was first to the cell.

5.4 A report by Officer B after PL 's collapse said PL had seemed troubled just before lunch following an encounter in the medications queue when he was surrounded by a group of prisoners including Mr Redbridge. Interviewed during our investigation, Officer B explained that, when he saw a group of three to five prisoners around PL at about 12:00, he was not close to them but looking up from the landing below. He did not recall where Mr Redbridge was, and he did not see any of the prisoners touch PL.

When he locked PL up, he did not seem physically unwell but just very serious and said he was all right. Officer B just thought he was having a bad day. Officer B confirmed that he did not at any point see anyone assault PL nor does he recall that any other member of staff said they had seen anyone assault him.

5.5 Officer C also remarked, after the event, on PL not seeming himself that morning. In his statement to the police on 30 July, Officer C said that at about 12:20 on 29 July he was on the 1s landing talking to Officer E when PL came down the stairs from the 2s and walked towards them. They asked him if he was OK and he replied that he was and walked off. Officer C and Officer E then walked towards the office, and both commented that PL did not look himself and seemed to be *'pissed off'* about something, though physically he appeared fine.

5.6 Interviewed during our investigation, Officer C told us he did not see PL having an argument with anyone. He did not at any time see anyone assault PL nor, to his knowledge, did any other member of staff tell him they had seen an assault. However, Officer C received information from two prisoners seeming to implicate Mr Redbridge in assaulting PL.

5.7 The police investigation records that CCTV footage of the medications area at one point showed PL and other prisoners in a group but there was no evidence of an assault nor any appearance of any threatening or verbal altercation.

5.8 A security report created at 19:00 by Officer C says that at 18:40 one of the prisoners who had been to PL's cell when he was discovered asked to speak to him privately and told him that PL was badly assaulted by Mr Redbridge in the medication line at lunchtime. This is the first report I have seen that names Mr Redbridge. At 19:35 Mr Redbridge was taken to the segregation unit suspected of a possible assault on PL He remained there until he was transferred to another prison in early September.

5.9 Later that day, and in following days, various prisoners confided to officers further information indicating that PL had been assaulted, possibly because he had been

stealing clothes from the laundry and possibly in the medication line at lunchtime. Some of the information did not name the assailant, some implied it was Mr Redbridge and one report apparently named him.

5.10 Some of the information received referred to the incident on PL on 15 July, naming Mr Buckingham and Mr Lancaster as responsible and saying it was as a result of PL giving hooch to Mr Durham instead of to them.

5.11 The clinical reviewers advise that the haematoma identified by X-ray on 29 July is the result of a physical injury, but that it is not possible to say if this was from an assault or a fall.

Assault on Prisoner Kent

5.12 On 29 July, there was another incident on K wing requiring outside medical assistance. Officer B reported that Prisoners Chester, Suffolk, Stafford, Berwick and Norfolk were seen on CCTV at 18:47 assaulting Prisoner Kent on Spur 1 then pushing him into cell 18, where they assaulted him further.

5.13 Supervising Officer (SO) F reported that Mr Chester was the main instigator who originally forced Mr Kent towards the cell. Then Mr Suffolk, Mr Berwick and Mr Stafford joined Mr Chester and they kicked and punched Mr Kent while Mr Suffolk held him in a headlock. This continued, then Mr Berwick went into another cell, Mr Chester and Mr Stafford forced Mr Kent into the cell. Mr Norfolk and Mr Suffolk joined them, where a further serious assault took place. Mr Kent crawled out of the cell a few minutes later and walked upstairs. He refused to say what had happened and wanted nobody to be challenged, but CCTV footage was available. Mr Chester was said to be clearly the main instigator.

5.14 The daily briefing sheet next day says that Mr Kent was found at 19:20 with injuries to the head. Staff suspected an assault by Mr Chester. Mr Kent was claiming he had slipped in the shower, and it was not a case of assault. An ambulance attended after

consultation with emergency out of hours contact. After assessment, Mr Kent was not required to attend hospital.

5.15 Safety Intervention Meeting minutes of 12 August show that CSIPs were opened on 31 July on Mr Stafford, who was moved to M wing, and Mr Norfolk, who was moved to H wing. Both were said to have been named as a perpetrator in numerous CSIP investigations and to have been involved in an assault on Mr Kent.

Observations and conclusions

5.16 Prisoner Mr Redbridge was suspected of assaulting PL, and he was isolated in segregation that evening. The evidence implicating Mr Redbridge was based solely on accusations or intimations by other prisoners. It felt far short of proof that Mr Redbridge had assaulted PL or even that any assault had taken place. Suspicion seems to have been prompted at first by the fact that Mr Redbridge was first to PL's cell, but CCTV footage showed that an assault in the cell was highly unlikely. There was some consistency between the information given by various prisoners, but I have seen no indication that at any stage any of them was questioned further to test the credibility of the information and none was interviewed by the police.

5.17 We have noted other serious assaults on K wing, including one within hours of PL's collapse (See paragraphs 5.12 to 5.14 and also Chapters 2 and 10). In that case, and in some of the others we have seen, the victim was unwilling to make a complaint but CCTV footage recorded the prisoners involved. Some of the suspected perpetrators were moved, but they were not placed in segregation and the incident was not reported to the police.

5.18 We were told by staff that what was distinctive about PL's case was that his condition was life-threatening, so there was a possibility of an offence of murder, and PL was unconscious, so had no capacity to provide any information or to say whether he wanted an investigation or for the police to be involved. In these circumstances, we agree that it was right for the prison to segregate Mr Redbridge, for his own

protection and that of any witnesses. It is unfortunate, however, that he remained in segregation so long. More effective collaboration between the prison and the police at an earlier stage might have reduced this. We say more in Chapter 9 about the arrangements for cooperation between the prison and the police.

PART TWO: THE INVESTIGATIONS BY THE PRISON AND THE POLICE

There were three investigations into what happened to PL on 29 July 2019:

- A simple enquiry conducted by custodial managers in the prison reported on 7 August 2019.

- A police investigation was closed on 15 October 2019 on the basis that all reasonable lines of enquiry had been completed, and there was insufficient evidence to take further action.

- In February 2020 the Governor of Stocken commissioned a management enquiry by the HMPPS Regional Safety Lead to re-examine the incident and to consider the context more broadly. This report is dated 17 February 2020.

CHAPTER 6 - THE IMMEDIATE INVESTIGATION BY THE PRISON

6.1 On 30 July the incident was reported to the police as a suspected assault on PL. Prisoner Redbridge was interviewed by his key worker, and Custodial Managers (CM) K and L were appointed to complete a fact-finding investigation.

Interview with Prisoner Redbridge 10:45 Tuesday 30 July

6.2 At the request of the Head of Safety and Equalities, Mr Redbridge was interviewed by his key worker, Officer M, at 10:45 on 30 July. The report describes it as a 'police interview'. However, no police were present, and Mr Redbridge did not have an adviser or representative. The police interviewed Mr Redbridge with his solicitor on 1 August. Officer M made a note of her interview but as far as I am aware it was not recorded.

6.3 Mr Redbridge was said to be relaxed, and speaking normally. He said he was using the toilet in his cell when he heard banging coming from next door. When finished, he went to the door of the next-door cell and saw PL lying on the floor, having what appeared to be a fit. He noticed water on the floor and tablet boxes and PL also had water over himself. Mr Redbridge called his cellmate to come and see, and a couple of other prisoners came over as well. They called for a member of staff and raised the alarm. Mr Redbridge said he only stepped into the cell for a couple of seconds and didn't go right in.

6.4 Mr Redbridge admitted having a verbal disagreement with PL '*the day before'* as PL was wearing some of his clothes. They had words, but PL gave the clothes back and that was the end of it. There is no further detail about the location or circumstances of this incident.

6.5 Mr Redbridge said PL had been beaten up badly a couple of weeks ago when some hooch he was holding went missing.

6.6 Mr Redbridge asked how PL was, and when told he was in an induced coma, threw up his hands and said it was nothing to do with him. He said CCTV would show he was in the cell only for seconds and the tape would probably show him just inside the door.

6.7 On 31 July, the police conducted an examination of PL's cell. Among other things they found a note accusing PL of stealing clothes and threatening reprisals. They found no evidence of recent drug-taking and no evidence of a disturbance in the cell. I am not aware of any further investigation of the origin of the note.

Serious Assault Incident Questionnaire

6.8 Custody Manager K completed a Serious Assault Incident Questionnaire. He described the circumstances in which PL was found; that healthcare attended; that PL was now in the Critical Care Unit in hospital; that the cause of PL's condition was not known but information was received that Mr Redbridge had assaulted PL that morning; and, although there were only single strands of intelligence implicating Mr Redbridge, due to the seriousness of PL's condition, Mr Redbridge was relocated in the segregation unit in the evening and his clothes were taken as evidence.

6.9 Possible causes of PL's conditions were thought to be that

- PL was assaulted by Mr Redbridge
- PL had taken an illicit substance during the lunch period
- his injuries were linked to a previous assault on 15 July.

6.10 PL had been taken by ambulance to Peterborough City Hospital then transferred to Addenbrooke's Hospital in the evening of 29 July. He had initially been put into an induced coma. He was taken out of this on 3 August but had not yet regained consciousness. The hospital had confirmed a fracture to the skull and bleed to the brain. The extent of his injuries was still unknown, but the hospital stated that it was unlikely he would make a full recovery.

6.11 Two prison family liaison officers initially tried to locate a friend whom PL had named as next of kin, but that person had been recalled to custody. On 30 July, the FLOs made contact with a relative, they visited her and remained in regular contact with her.

6.12 The incident had been reported to the police and they were investigating.

The fact-finding report – signed off 7 August

6.13 The report names Mr Redbridge and his cellmate Mr Durham as possible perpetrators. It contains similar information to the Questionnaire but some additional information.

- It notes that after the incident on 15 July, PL was placed on report for being in possession of fermenting liquid.
- The hospital had confirmed that the fracture to PL's skull was more likely to have occurred as part of an assault rather than by him falling backwards, under the influence.
- CCTV footage had been provided to the police, who had reviewed profiles of suspects.
- A joint police-prison staff search of PL's cell had been conducted. Some tablets and a note suggesting PL was going to be assaulted were found.
- A CSIP referral had been completed and an investigation was taking place but could not be completed as PL could not be interviewed.
- CCTV footage showed a verbal altercation between PL and Mr Redbridge but no physical contact.
- There was no intelligence to indicate that PL had taken an illicit substance during the lunch period. Toxicology results at the hospital were clear. The police had seized tablets found in the cell.

6.14 The report gave further information about the previous incident on 15 July:

- It noted that PL and another prisoner, Mr York, were both found with injuries that day at about 18:40. PL sustained facial injuries and a cut to his ear. He was taken to Peterborough City Hospital where it was understood PL's ear was stitched and he was discharged without any further treatment or assessment.

- CSIPs for the injuries to both PL and Mr York resulted in no further action as both denied they had been assaulted and would not give any information. Both said they were happy to remain on the wing.

- Another prisoner told an escorting officer that PL was assaulted because he sold elsewhere hooch that he was meant to be brewing for prisoners Mr Chester, Mr Norfolk, Mr Durham and Mr Cornwall.

6.15 The report identified lessons indicated so far:

- The clothes placed in evidence from Mr Redbridge were possibly not the clothes he was wearing at the time of the incident. After reviewing the CCTV, it would have been good practice to remove those items from the cell as possible evidence.

- When unlocking, Office J had not noticed PL lying on the cell floor. Staff unlocking cells should be reminded that they should always check the welfare of the men.

6.16 Areas of good practice were:

- The incident was dealt with as a Code Blue and in a professional manner.

- Staff were proactive in gathering intelligence and forwarding it appropriately to build up a picture of the incident.

6.17 Recommendations were:

- Staff briefing on welfare checks at unlock to be completed by 31 August.
- Disruption moves for identified potential perpetrators/bullies. These were said to have been completed.

What staff told us

6.18 We asked Custodial Manager L about the CCTV footage of a verbal altercation to which the fact-finding report referred. Mr L told us that a camera covered the area close to the medications hatch on K wing but not the whole area there and not the bench. Speaking from memory, Mr L said that that from the camera footage he only saw confirmation of what a staff member had said and prisoners walking away. There was no footage showing an altercation, but just of PL coming into screenshot and Officer E walking away with PL and talking with him. There was no indication of any injuries, and no evidence of an assault. To the best of his knowledge, Mr L thought this occurred on 27 July, which was when Officer E said he had seen an altercation. For 29 July, Mr L viewed only the CCTV footage immediately prior to PL being found.

6.19 For the fact-finding investigation, Mr L had spoken to Supervising Officer F on the phone. As far as Mr L could remember, SO F said he could not remember anything of note. There was just a bit of shouting and he and Officer E went up there and found nothing and walked away.

6.20 CCTV footage for 27 July was not included in the CCTV footage that was provided to the police and which they made available to me. We were not able to interview Supervising Officer F or Officer E who had both left the prison at the time of our investigation.

6.21 Mr K told us he had no contact with the police investigation.

CHAPTER 7 - THE POLICE INVESTIGATION

7.1 The police were notified of PL's collapse in the morning of 30 July. The prison provided the information known at that point, including information received from staff and prisoners, and that PL had been assaulted previously on 15 July.

7.2 On 31 July, the police attended the prison to examine PL's cell. The cell had been secured with a padlock. A handwritten note on the floor read, '*Dirty old woman robber! Your gonna pay for my boxer shorts which you nicked…the grey Hugo Boss they were £35 you dirty bastard*'. I am not aware of any enquiry of who might have sent this. A small pill and an improvised smoking pipe were found. There appeared to be old, faded, blood stains on the bedsheet and pillowcase. The police took possession of the note, pipe and pill. The examiner noted that there were many hard surfaces in the cell, both fixed and mobile, that could have come into contact with a person's head, but no obvious signs of disturbance and no forensic evidence to support an explanation of how the injury occurred.

7.3 Six prisoners said to have been surrounding PL in the medications queue were identified as persons of interest. On Thursday 1 August, Mr Redbridge was interviewed by two police officers in the presence of a solicitor as a suspect under caution. None of the other prisoners identified as persons of interest was interviewed.

7.4 Mr Redbridge denied that anything had happened in the morning of 29 July or that he had ever assaulted PL. He said he had a go at PL on Saturday (27 July) for stealing clothes from the laundry. He would not say what the item of clothing was. He said that the supervising officer and Officer E spoke to him on Saturday afternoon and that he was accused of slapping PL but he denied this, saying that it was because PL had flinched, but he hadn't touched him.

7.5 Mr Redbridge said something similar in his interview with his keyworker though seems to have referred to Sunday not Saturday. I have not seen any contemporary record

about this alleged incident, either among security reports or in the wing observation book. However, there is a reference to it in the subsequent management enquiry commissioned by the prison – see below, paragraph 8.2. Both SO F and Officer E have left the prison service and we were unable to interview them.

7.6 The police obtained statements from Prison Officers B and C and from the ambulance technicians. They requested CCTV footage for all cameras on the wing and the medications area, from unlock on 29 July to the securing of the cell after PL was taken to hospital, and for notes and any camera footage relating to the incident 15 July, and the alleged incident on 27 July. The officer responsible provided CCTV footage for 29 July from cameras covering the area outside PL's cell and the camera that covered part of the area outside the medications hatch. Only part of that area was covered by CCTV.

7.7 On 8 August, the CCTV officer told the police that the volume of footage requested would take a few more days to produce. In fact, I understand that the additional footage for 29 July was provided to the police on 12 September and police were required to provide a USB memory stick. The police also asked for medical records which I understand the healthcare provider was unwilling to release without PL's consent, which he was not in a condition to give at the time.

7.8 On 8 August, the police were told that PL was now conscious and breathing on his own. He was able to follow commands but not yet able to talk. On 1 September he was still reported to be unable to communicate.

7.9 On 1 September the police assessment was that from CCTV footage obtained so far it appeared no one entered PL's cell other than to find him. Further CCTV was still awaited. Mr Redbridge's denial of any assault could not be disproven. Upon completion of enquiries in progress, it was likely that all relevant enquiries had been completed and, without an explanation from PL, it might not be possible to know any more.

7.10 On 20 September the police noted that further CCTV footage had been supplied after the police provided a USB stick. The investigating officer summarised the information obtained so far. Her report says PL was unable to recall what happened to him and it was not known whether he would ever know. He had confirmed he was assaulted for keeping someone's socks. He confirmed he used spice and thought he had smoked it about two days before the incident but could not be sure. He was receiving therapy for paralysis down the right side of his body, and it was not known whether this was temporary or not. He had fluctuating capacity and it was not known if he would recover his full memory. (The date and source of this information is not clear in the police records provided to me, but in a subsequent email to the prison management enquiry the investigating officer said that, having been told by the hospital that PL was able to communicate, she had visited him and with his permission updated the prison officers about his condition.)

7.11 The investigating officer concluded there was no evidence to suggest an assault had taken place. CCTV did not show anything relevant, there was no material evidence, and the victim was unable to recall what happened. The case was reviewed. It was noted that intelligence naming Mr Redbridge had not been corroborated. The short time from Mr Redbridge opening the door and others joining him suggested it was likely that PL was already unconscious on the floor at that point. Medical evidence was inconclusive. Doctors were unable to say what caused PL's loss of consciousness and subsequent medical issues. Assault could not be ruled out but it was also quite probable that PL's condition was caused by illicit drug use. On 15 October the case was filed on the basis that all reasonable lines of enquiry had been completed, and there was insufficient evidence to take further action.

CHAPTER 8 - THE MANAGEMENT ENQUIRY IN FEBRUARY 2020

8.1 On 10 February 2020, the governing Governor of HMP Stocken commissioned the North Midlands Regional Safer Custody Lead, Mr N, to conduct a management enquiry with the following terms of reference and to report by 10 March.

- Investigate the general circumstances leading to a potential (but unconfirmed) serious assault on PL on 29 July 2019
- Was HMP Stocken in receipt of any information that might have suggested that PL was 'at risk'?
- If so, were appropriate actions taken to mitigate any risk; if not, were there any missed opportunities?
- Was the incident itself managed properly?
- Were there any lessons that could be learned from the incident?
- Make recommendations to prevent a further incident of this type occurring at HMP Stocken.

8.2 Custodial Manager L was assigned to assist. He made enquiries about the alleged incident on 27 July. He reported that Supervising Officer F heard a commotion outside the medications hatch by the bench where there was no CCTV but did not see anything, PL did not display any injuries and said nothing had happened. The report says CM L had not been able to speak to Officer E, who was on nights.

8.3 Mr N saw an email of 27 September from the police investigator, in which she said that the prison had not supplied certain information she had requested. This included medical information which had not been supplied by the healthcare provider despite several requests and a data protection application; CCTV footage relating to the incident on 15 July and the alleged incident on 27 July; CCTV footage for 29 July for all the cameras on K wing. Footage was provided in August for two cameras, then on 3 September the prison asked the police to supply a USB stick for the rest. The family liaison officer had not been in touch with the police as requested. The investigating

officer said that she had not been given a dedicated liaison point (SPOC) and had to chase through various prison personnel for different kinds of information. She suggested it would be beneficial for there to be a more streamlined process for cooperation.

8.4 The enquiry interviewed Governor P, who was Head of Safer Custody and Equalities, SO F, supervising officer on K wing, and Officer Q who managed CCTV. Officer E was said to be unavailable as he was on nights, so he was not interviewed. PL was interviewed in hospital. I have not been able to obtain any records of the interviews.

8.5 Documents consulted were the initial fact-finding report, Mercury intelligence profile (ie security reports) and various emails. The enquiry consulted the police investigating officer.

8.6 The CCTV officer provided a log of when CCTV footage was requested and supplied. Some had been extracted on 29 and 30 July and some on 11 September. Officer Q, who handled the CCTV footage, recalled that he had viewed some of the material with police officers and understood that they had seen all they required. He said there was no footage from 15 July and none covering an alleged incident at the medications hatch where there was a blind spot.

Events considered by the enquiry

8.7 21 March, when PL informed staff he was under threat on K wing and at first was refusing to return to the wing.

The incident on 15 July

8.8 15 July, when PL sustained facial injuries and a cut to his ear. A CSIP referral was submitted but it was closed as PL refused to divulge any information and stated he was safe on the wing and *'insisted'* on remaining in that location. It was unclear whether CCTV evidence was available or reviewed. (I do not know the basis for saying

that PL insisted on staying on the wing. The CSIP investigation says he said he was *'happy and safe'* on the wing.)

8.9 A case note by PL's key worker on 22 July said he was OK but bored with having no work. The officer asked him about his injuries, and he said he got rushed but did not go into detail as '*wing staff already know*'.

8.10 Intelligence stated it was possible PL had been assaulted due to brewing hooch and selling it on.

8.11 A prisoner later named four individuals (Mr Chester, Mr Norfolk, Mr Durham and Mr Cornwall) involved in assaulting prisoners on the same day. Information was received that the wing was *'going crazy'*. Staff were aware of a further victim, Mr York, who also failed to provide any details during a CSIP investigation.

8.12 Interviewed in hospital on 11 February 2020 by the Regional Safety Lead, PL said he had been assaulted by a group of lads who were drunk and going around the wing assaulting others. He named Mr Chester and Mr Lancaster.

An alleged altercation near the medications hatch on 27 July

8.13 This area was supervised by staff but not covered by CCTV. Mr Redbridge said he had a verbal altercation with PL. The enquiry report says that SO F recalled that Officer E heard a commotion but did not see anything. PL did not show any injuries and said nothing had happened.

8.14 When asked in February 2020 about a possible incident on 27 July at the medication hatch, PL stated he had an altercation with Mr Redbridge and was punched four times in the side of the head which made his head ring. He said he remembered where the staff were and that they intervened. The altercation was apparently over a pair of socks. When pressed about him now remembering this, PL said he hadn't

remembered but had been told by a psychologist what had happened. When told that it was Mr Redbridge who found him unconscious, PL said that's '*because he felt guilty for assaulting him*'. When pressed for a time he said at the medicines hatch on 27 July.

29 July - PL discovered unresponsive on the cell floor

8.15 CCTV showed Mr Redbridge looking through the observation panel then alerting Mr Durham. They activated the cell bell and Prisoner Mr Berwick activated the general alarm. Code Blue was called without delay, healthcare attended, and PL sent to outside hospital.

8.16 Information was received that PL's condition was due to smoking spice, and that he had been assaulted for stealing clothes from the laundry.

Findings of the management enquiry

8.17 The report found that CSIP referrals had been submitted and investigated. PL had refused to disclose any information and insisted he was safe and did not wish to move. The police investigation provided little further clarification of the circumstances and details of the incidents. Requests by the police were actioned as soon as practicable but there appeared to be some instances of communication difficulties within both the police and the prison resulting in delays.

8.18 CCTV covering the scenes and timings were supplied but provided no evidence of assaults.

8.19 Medical evidence requested by the police was never supplied.

8.20 Following safety analysis after the incident on 15 July, a number of ''disruption moves took place, reducing the risk to others from the specific group.

8.21 It had not been possible to determine how or when PL's serious injury was sustained and whether there was a further assault on the day he was discovered unresponsive in his cell. CCTV from unlock to lunchtime did not identify any incidents.

8.22 Intelligence received before 29 July was acted on by staff but investigations by the safety team were difficult as PL refused to provide any information or details that would have allowed the staff proactively to safeguard him if deemed necessary.

8.23 In the period after PL claimed he was under threat on K wing he had weekly meetings with his key worker which are noted in case notes in detail and he did not raise any issues about being at risk on the wing.

8.24 Unfortunately, he was not discovered at the earliest opportunity by staff unlocking in the afternoon. CCTV showed the officer unlocking the door then moving on without gaining a response.

8.25 Once Mr Redbridge was identified as possibly being involved in an assault, he was located in the segregation unit and his clothes seized, but it was suggested these were not the clothes he was wearing in the morning. His cell should have been secured so that any further evidence could have been secured and retrieved.

8.26 Throughout his time in prison, PL had not hidden the fact that he used a variety of drugs and had done so for many years. Interviewed in February 2020, he confirmed that he had been smoking psychoactive substances heavily during the date ranges in question, including the immediate period before being discovered unresponsive in his cell.

8.27 Interviewed in hospital in February 2020, when consideration was being given to his discharge from prison under home detention curfew, PL was more open than before in disclosing names and dates of incidents but said this was information his psychologist had given him. He said he would not cooperate with any police investigation.

8.28 The relationship between the police and assigned prison staff appeared strained, with some requests not actioned and the logistics of providing key evidence difficult. Contacting the right person for information, advice and evidence was problematic, with inconsistent contacts. Despite this, most evidence was supplied and there was some indication that the police had not always communicated clearly as to what information had been received or was still required. However, medical reports were never supplied and memory sticks for recording CCTV were not readily available.

8.29 The Head of Function was designated Single Point of Contact (SPoC) but workload and other demands on their time led to some difficulties.

8.30 NOMIS entries for all those involved throughout the incidents are inconsistent, with many instances not recorded.

8.31 The management enquiry made the following recommendations:

- Ensure staff are reminded of the importance of recording all incidents, occurrences and actions taken on NOMIS Case Notes including submission of CSIP referrals.

- Consider scene preservation/evidence gathering training for Band 4, Band 5 and Senior Management Team members. The local police force might help with this and the report gave a contact.

- Identify experienced and competent staff for incident management to ensure all evidence is secured at point.

- Identify appropriate Single Point of Contact and assist for all investigations referred to the police ensuring that consistent and positive communications are easily achieved, and requests acted on without delay.

- Ensure that the prison has the equipment required for effective evidence gathering.

- Use the expertise of the prison's Police Intelligence Officer.

- Remind staff of the importance of completing a response check when unlocking prisoners.

- Investigating staff to record whether CCTV evidence is available and whether it was reviewed. It was unclear whether CCTV was available or reviewed for the incident on 15 July 2019.

8.32 Positive actions noted were:

- Recent pro-active initiatives by security and safety were achieving positive results in the discovery of weapons and fermenting liquid.

- A renewed whole prison approach to CSIP referrals and investigations ensure that all incidents of violence and anti-social behaviour are reported and investigated.

- Prison/police partnership meeting held on 14 February 2020.

CHAPTER 9 - OBSERVATIONS AND CONCLUSIONS FROM THE PRISON'S INVESTIGATIONS AND THE ARRANGEMENTS FOR COOPERATION WITH THE POLICE

The prison's investigations

9.1. It is right that we commend the quality of both the immediate investigation conducted in the prison and the management enquiry commissioned later by the Governor. It is regrettable that Officer E, who was said to have witnessed a commotion, was not interviewed for the management enquiry because he was working night shifts. I am surprised that this was an insurmountable problem. Unfortunately, we were not able to interview Officer E either as he has now left the Prison Service. In other respects, the enquiries seem to have been thorough, professional, timely and insightful. I have no doubt their findings and recommendations have been helpful to the prison. The scope of the investigations was in compliance with Prison Service policy on investigating incidents of serious harm in PSI 15-2014. We have some observations about some questions that were not resolved by the investigations, and about the processes for securing evidence and for effective cooperation between the prison and the police.

9.2. Apparently, no records were retained of how and when the evidence on which either of the prison's investigations reports relied. There were no statements from staff, and no interview notes. We have seen only the final reports. Staff submitted various security reports about information received, and we are aware that the early involvement of the police meant that their investigation had primacy. But, in our view, good practice requires that the evidence obtained by prison service investigations by oral enquiry or written statements should be signed, dated, collated and retained to show the evidence on which the report relies.

CCTV

9.3. It is evident that the police investigators felt some frustration about the arrangements for liaison with the prison. This was partly due to difficulties in obtaining the CCTV

footage they requested. During our investigation we were told that the system of CCTV at the time was cumbersome, comprising different systems installed at different times, and not always well maintained. We were told that to download all the footage requested by the police would have taken some two weeks. Moreover, during downloading, availability to view footage in real time was compromised. We understand that funds have been secured to upgrade part of the system which will be more accessible for security staff and that material from the new system can be directly uploaded for the police if required.

9.4. The police did not receive all the CCTV footage they requested. From our examination of all the evidence available, we think it unlikely that any significant evidence was overlooked because of this.

Supervision of the medications queue

9.5. Several staff told us that part of the area on K wing where prisoners queued for medication was not covered by CCTV. Prisoners were said to be aware of this and to take advantage of it. However, staff also commented that CCTV was not a panacea. There would always be blind spots; staff were not available to monitor CCTV in real time; CCTV was not a substitute for effective staff supervision and engagement.

9.6. Some staff expressed concern about the staffing to cover the medications queue, which they considered a critical area because of prisoners congregating there and the problem of prisoners diverting medication, possibly because of coercion. However, others said this was a larger problem of staffing numbers on the wing. Supervision of the medications queue needed to be proportionate, and a case could be made for enhanced supervision of various areas.

9.7. We were told that one officer was assigned to supervise the medications queue, but sometimes that officer had to go into the medications room behind a closed door, leaving the queue unsupervised. The other officer was a ‘runner’, unlocking people to join the queue as others left.

9.8. We note that in the Action Plan following the 2019 report on Stocken by HMIP, a review of procedures for supervision of medication queues by custodial staff would be completed by September 2019. Staff supervising medications queues would be trained.

9.9. Staff's opinions varied as to whether there was currently a problem of inadequate supervision of the medications queue on K wing, but we drew the issue to attention of the (new) Head of Security during our interview with her.

The relationship with the police investigation

HMPPS policy on referral to the police

9.10. Prison Service Instruction 64-2011 on the Management of Prisoners at risk of harm says:

Any alleged crime can be reported to the police either directly or through the local Police Intelligence Officer. Where the victim of a violent incident is a prisoner, their wishes must be considered. There are approximately 15,000 violent incidents in prisons each year. It would place a significant and unreasonable demand on police resources to investigate all these incidents. In many cases a more immediate and effective outcome would be gained by use of internal systems. However, it is recommended that the more serious violent offences are referred to the police {page 38}.

Crime in Prison Referral Agreement

9.11. This joint protocol between HMPPS, the Police Chiefs' Council and the Crown Prosecution Service was issued in May 2019.

9.12. There is a presumption that the prison will contact the police immediately in the event of a very serious incident, including a sudden death or life-threatening injury, where staff require the immediate attendance of police to protect life or the integrity of the establishment. In such cases the prison should discuss the forensic strategy with the police. Where immediate attendance is not required to protect safety, but a serious incident has occurred including any assault resulting in inpatient treatment in outside hospital, the incident must be referred to the police not later than seven days after the event.

9.13. In making a referral, the prison will, among other things,

- provide a full description of the incident, including details of offenders, victims and witnesses and any previous relevant behaviour.

- preserve the evidence ensuring continuity (including CCTV and body worn video cameras) in accordance with prison service instructions on dealing with evidence

- enable the police to attend the prison and take witness statements

- provide access to the crime scene

- help arrange staff to be available to provide statements to the police

- provide information about any relevant prisoners transferred elsewhere.

9.14. Following a referral, the police will acknowledge receipt to the prison's Crime in Prison Single Point of Contact (SPoC) and keep the SPoC regularly updated at least once a month.

9.15. In this case, the main frustrations expressed by the police were delay in providing CCTV footage and the apparent lack of a single point of contact. Governor P told us that the Single Point of Contact would usually be the Head of Safety or the Head of

Security. She recalled that communications were not helped by her own leave and probably that of the police investigating officer.

Preserving evidence

9.16. We understand that as a result of the findings of the management enquiry arrangements were made for the police to provide training to prison staff on preservation of evidence.

Recommendation

9.17. We recommend that the prison takes note of the problems that occurred in this case and ensures that where the police are investigating an incident in the prison, clear arrangements are made for a single point of contact in the prison and for another staff member to deputise if they are absent.

The segregation of Mr Redbridge

9.18. One consequence of the duration of the police investigation was that Mr Redbridge was held in segregation from 29 July until 1 September when he was transferred to another prison. No charges were brought against him in connection with the injuries to PL.

9.19. For part of his time in segregation Mr Redbridge had an ACCT[1] plan, which was opened after he handed over a noose to staff in the morning of 31 July. He said he had fashioned the noose in frustration at persistent banging through the night from a neighbouring cell. He was issued with a radio and told he could move to another cell as soon as one was available.

[1] ACCT is Assessment, Care in Custody and Treatment. This is the scheme in force at the time for protecting prisoners at risk of suicide or other self-harm.

9.20. A further source of frustration for Mr Redbridge was worrying about his property, which was left in his shared cell. On 5 August, he complained that he had not received his property or his vapes. It was apparently left to his cellmate to pack when the cellmate was transferred to another prison. The records say that considerable excess property was confiscated from the cellmate when he was transferred. A note of 15 August says this would be checked against Mr Redbridge's property card but this would take some time.

9.21. We have examined the records of Mr Redbridge's segregation and were satisfied that it was properly considered and regularly reviewed in accordance with requirements including consideration of his ACCT status and oversight by the Independent Monitoring Board. However it is regrettable that it was necessary for him to remain in segregation for so long and the way his property was handled was not satisfactory.

Healthcare records for the police investigation

9.22. The police record says that they applied to the prison's healthcare provider for access to PL's medical record, but this was not supplied.

9.23. The healthcare provider, PPG, say they have not located any record of a request for disclosure of healthcare records in this case, so are not able to comment on the reasoning behind any refusal to disclose. However, they say that the police have no general or automatic right to information and PPG are required by law to disclose information to the police only where there is a statutory requirement to do so or a court order requiring it. PPG comments that, as healthcare provider, they owe a duty of confidentiality to their patients, and disclosure to the police without legal justification can be a breach of both statutory data protection and the duty of confidentiality owed by individual professionals and by PPG to their patients.

9.24. PPG says that disclosure without consent must be:

- necessary for the purposes of the prevention or detection of an unlawful act

- carried out without consent of the data subject so as not to prejudice those purposes, and
- necessary for reasons of substantial public interest.

9.25. PPG considers these criteria when making a decision as to whether to disclose information or not.

Recommendation

9.26. The police say that they were unable to obtain PL's healthcare records because the healthcare provider required his consent. PPG say they have no record of a request from the police but have explained, rightly, that they are bound by safeguards to protect the personal data of their patients, expect in certain prescribed circumstances. We recommend that PPG review their protocols for supplying data for the investigation of a suspected crime where the alleged victim has no capacity to give or withhold consent. Any request to disclose information to the police should be recorded, with the reasons for the decision to disclose or to refuse disclosure.

PART THREE

In this part of the report we examine some issues that have emerged from our investigation and our consideration of any lessons to be learned.

These are:

- Communications with the ambulance service
- The prevalence of violence on K wing at the time
- The prison's policies to reduce violence.
- Reports of the Independent Monitoring Board
- What people told us about violence at Stocken prison

CHAPTER 10 - COMMUNICATIONS WITH THE AMBULANCE SERVICE

Introduction

10.1 An officer on the wing called Code Blue at 14:01 on 29 July. This is the prison service's internal emergency call for patients suffering chest pain, difficulty in breathing, unconscious, choking, fitting or concussed, a severe allergic reaction or a suspected stroke. The prison Control Room called 999. The ambulance arrived at the prison at 15:05 and the ambulance technicians were with PL at 15:17.

10.2 The East Midlands Ambulance Service NHS Trust (EMAS) has provided the records of the emergency call about PL and their attendance at the prison. We have also seen statements made at the request of the police by the two Ambulance Technicians who attended. At our request, EMAS have kindly reviewed their records and have sent us their report.

National and local policies: HMPPS

10.3 PSI 03/2013 is the national instruction which sets out a framework for calling emergencies consistently over the establishment radio network in all prisons. It was in force from February 2013. Its objectives were:

- to provide guidance to staff in efficiently communicating the nature of a medical emergency;
- to ensure staff called to the scene bring the relevant equipment; and
- to ensure there are no delays in calling, directing or discharging an ambulance.

10.4 Each prison was required to draw up local protocols for responding to emergencies. The instruction stated that local protocols must clearly define the nature of the medical emergency with the use of a two level code system that differentiates between a blood injury and all other injuries. It is recommended that Code Red should be used for blood/burns and Code Blue for breathing/collapses.

10.5 In July 2019, NTS 73.19 was the HMP Stocken notice to staff about use of Code Red and Code Blue. Code Red is the emergency code for severe loss of blood, severe burns or scalds or suspected fractures. Code Blue was to be used for chest pain, difficulty in breathing, unconscious, choking, fitting or concussed, severe allergic reaction, suspected stroke

10.6 The notice states that in cases of Code Blue and Code Red it is mandatory:

- for the control room to call an ambulance and await updates from the scene
- for healthcare, where available, to attend with equipment, or
- where no nurse is available, other staff to attend with necessary equipment,
- for the prison Gate to prepare to receive the ambulance
- to arrange prison escort staff to accompany the ambulance
- and escort staff and equipment in preparation to escort the prisoner to hospital.

10.7 The national instruction PSI 03/2013 was amended in September 2021 to clarify that Codes Red and Blue were terms for use within the prison only and not for communicating with ambulance service staff, who were unlikely to be familiar with them; and that the member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, to enable them to share this with ambulance service staff for use in the triage process.

10.8 The Stocken local protocol was reissued on August 2022 as NTS 130.22. An addition to the previous notice says:

'The control room operator will ask whether the patient is conscious and breathing and whether CPR has commenced, which is vital information to be passed on from the scene so the emergency services can prioritise the incident accordingly.'

East Midlands Ambulance Service (EMAS) Emergency Medical Dispatch Protocols

10.9 At the request of the investigation, the East Midlands Ambulance Service NHS Trust has kindly reviewed their response in this case and explained the process that was followed. EMAS has told us that each ambulance service has its own protocols for emergency medical dispatch, so policies and procedures vary in different areas. Although PSI 03/2013 advises against relying on the terms Code Red and Code Blue in communications with the emergency services, EMAS protocols make specific provision for prison related incidents, and in allocating priority they use the Code Blue and Code Red conventions in use in the prisons.

10.10 EMAS explains that most 999 calls they receive are triaged using the Advanced Medical Priority Dispatch System (AMPDS), which is an internationally recognised triage system taking callers through a series of questions about the patient's presenting condition. A Government Panel of Health Care Professionals has assessed each code within AMPDS and assigned a response level based on Clinical need. Ambulance Trusts are required to comply with the response times allocated.

10.11 However, in the case of prison calls, EMAS says there is usually minimal information known at the time of the initial 999 call. Therefore EMAS deems Code Blue/Code Red to be the most appropriate process, as answering the AMPDS triage questions may result in a lower response being assigned to the 999 call.

10.12 Section 9.44.1 of the EMAS protocols states that the prison will call 999 and specify a request for Code Red or Code Blue response. Code Blue is understood to mean immediately life-threatening and Code Red non-life-threatening.

10.13 Section 9.44.2 states that If a caller does not provide Code Red or Blue, then the Emergency Medical Dispatcher must clarify whether it is a Red or Blue Code. If neither is given, the call is processed through the AMPDS triaging systems.

Ambulance Response Categories

10.14 I am advised by the clinical review to the investigation that Categories 1 to 4 for ambulance dispatch were introduced nationally in 2017 as part of the Ambulance Response Programme:

- Category 1 was for people with life-threatening illness or injuries such as cardiac arrest or severe allergic reaction.
- Category 2 was for emergency calls such as burns, epilepsy or strokes, which may require rapid assessment and/or urgent transport.
- Category 3 is for an urgent problem, such as non-severe burns and diabetes.
- Category 4 is for less urgent calls such as diarrhoea and vomiting or urinary infection. Patients may be given advice over the telephone or referred to another service.
- Category 5 was added in 2018, essentially splitting Category 4 into two: namely, those where a non-emergency physical response was required eg non-injury falls where the patient just needed assistance in picking up; and Hear and Treat, that is calls deemed suitable for a clinician to assess over the phone.

(For further information see 'Ambulance Response programme', 'NHS England Ambulance system indicators specification' and 'North-East Ambulance Service NHS Foundation Trust, Understanding ambulance response categories' 2011).

What happened in PL's case

First 999 call 14:02 11657918

10.15 According to the Ambulance Computer Dispatch Record (CAD) 11657918 the first call was made by the prison's control room at 14:02. The call, but not the time, is noted in the prison control room communications log.

10.16 The Ambulance Service's audio recording of the call indicates that the caller said that the patient was breathing but unconscious, he could not say whether the breathing was noisy, he had received a Code Blue call, the patient was fitting, healthcare was on

the way from the other end of the prison, he was not in contact with anyone who was with the patient, this was all the information he had, but he would call back as soon as he knew more. He was told that the service would open a new call with a new reference number when he called back.

10.17 EMAS says that this initial call was coded as 'Code Blue amber (Convulsion/Fitting)' requiring a category 2 response.

Second call 14:29 11658008

10.18 The prison communications log says the ambulance service was called a second time at 14:26. The service said an ambulance was on the way, but they could not give an estimated time of arrival. The log notes the new reference number.

10.19 The Ambulance Service Record CAD 11658008 records the second call at 14:29. The caller said he had more information from the nurses, and was calling for an expected time of arrival for the ambulance. The patient was still unconscious, on oxygen and, though he had no history of it, had had some kind of seizure. The caller was not able to give the patient's age or name.

10.20 The call handler said she would open another call, as the patient was now unconscious and on oxygen. She said there was a crew travelling but she could not say how long it would be. Both the caller and the call handler used the term Code Blue.

10.21 EMAS says that this second call was similarly coded Code Blue amber, requiring a Category 2 response, and that the dispatcher who took the call noted 'Code Blue – unconscious and on oxygen.'

10.22 A double-crewed ambulance was allocated to travel to the scene at 1430.

Third call 14:48 11658067

10.23 The prison communications log notes a further call at 14:47 to inform the ambulance service that the patient could go into cardiac arrest. The log says the priority was upgraded to Category 1. It does not record the new reference number.

10.24 The ambulance service computer dispatch record CAD 11658067 records this third call as at 14:48. From the audio recording, the caller from the prison explains he is calling for expected time of arrival as the GP, who was now with the patient, was concerned that the patient might go into arrest.

10.25 The emergency call handler makes enquiries and comes back to say they had allocated the nearest available ambulance in response to the previous call, but it was 20 minutes away. The caller protests that his first call was at 14:00 and he had told them originally it was a Code Blue and that the patient was breathing but unconscious; then at 14:26 he had given a reappraisal to say he was still unconscious and now on oxygen and he had been told that an ambulance was on the way.

10.26 The call handler says that it was the same ambulance that had already been allocated but, as the patient was now not breathing, the priority has been raised to 1 so the ambulance would not be diverted to a more urgent call.

10.27 The ambulance patient record says the ambulance arrived at the prison gate at 15:05.

10.28 In her statement for the police, Ambulance Technician 1 says the job initially came through with a Code 2, which is not the most serious code, and from memory she thought it came through as a 'query seizure'. (Code 2 means a serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport and with a target response time of 40 minutes).

10.29 At 14:49, as they were travelling to attend, it was upgraded to a Category 1, which Ambulance Technician 1 said was still not the most serious code but it meant a shorter target response time (15 minutes according to Quality Standards). At this point, the ambulance crew asked over the radio if there were any paramedics to attend as they thought that if the patient was still fitting, he would need paramedic attention.

Access at the prison

10.30 Ambulance Technician 1 says that they arrived at the prison's main gate at 15:05 and went through security procedures to get into the prison. Inside the main gate they were accompanied by a prison officer who took them though several further gates. They parked the ambulance at the back of a building on the road and arrived at PL's cell at 15:17.

10.31 The prison communications log does not record the time of arrival of the ambulance or its departure to hospital but the Escort Record (PER) says the ambulance left the prison with PL and escorts at 16:10, arriving at Peterborough General Hospital at 16:45, where PL was located in Resus.

Response time for the ambulance

10.32 EMAS says that at the time of this case the service was experiencing a high demand for emergency response. They were applying their Clinical Safety Plan. This is designed to manage demand and resources during periods of high call volumes where the supply of ambulance services is potentially insufficient to meet the clinical demand of patients. The purpose of the plan is to prioritise resources to ensure a response to the most seriously ill patients in an appropriate timescale.

10.33 EMAS says that staff sent an ambulance as soon as they were able to do so and this was in line with Trust policies and procedures. The care provided to the patient once EMAS arrived at the scene was appropriate. However, it was noted by the crew that there was a delay in gaining entry to the prison.

Observations and conclusions

10.34 We have learned that each Ambulance Trust adopts its own emergency dispatch protocols. It is notable that EMAS routinely uses the prison's attribution of Code Red or Code Blue to allocate the degree of priority to an emergency call. This is contrary to the assumption and the advice in PSI 03/2013 but it is a practical response to the fact that a 999 caller from a prison is unlikely to be with the patient and consequently

not able to give accurate answers to the standard triaging questions in the internationally recognised Advanced Medical Priority Dispatch System (AMPDS).

10.35 The clinical review to the investigation has advised that the symptoms/conditions listed in the HM Prison guidance for Code Blue and Code Red calls can, due to the way Ambulance triage systems work, attract different call categories. However, EMAS indicates that a lack of information in emergency calls from a prison might result in an inappropriately low priority being allocated if they were to rely solely on the triaging questions in AMPDS.

10.36 Recent amendments to HMPPS national and local protocols recognise the importance of providing all relevant information to the emergency service, as the priority given to the call will depend upon it. But it is characteristic of medical emergencies in prison that the member of staff who speaks to the ambulance service is unlikely to be with the patient so is passing on information second-hand. There may be technological solutions which would enable a staff member who is with the patient to speak directly to the emergency service, but we are not aware of any such systems in use at present. In any event, HMP Stocken and the national Safer Custody unit may wish to review how information is gathered and shared with the member of staff designated to make 999 calls, having regard to the ambulance service priority categories and possibly a structured communications tool such as SBAR as described in the clinical review. [1]

10.37 The ambulance arrived at the prison gate at 15:05 and the crew were with PL 12 minutes later at 15:17. It was noted in the Stocken 2019-2020 Safety strategy that the Prisons and Probation Ombudsman had made a repeat recommendation on three occasions with regard to emergency code response and the length of time for an ambulance to be escorted to the patient.

[1] SBAR (Situation, Background, Assessment, Recommendation) is a structured form of communication to enable information to be transferred accurately between individuals. For further information see NHS England/NHS Improvement online library of quality service and redesign tools.

Recommendations

10.38 We recommend that the Governor of Stocken (locally) and HMPPS (nationally) review the present arrangements for communications with the ambulance service to examine whether current policy and practice appropriately reflects the ambulance services' system of allocating priorities.

10.39 In PL's case it is not clear whether staff were primed to facilitate access to the prison and to K wing and we invite the Governor to examine whether the 12 minutes from arrival at the main Gate to attending a patient on K wing is unavoidable or whether the process of accessing the wings in emergencies can be made more efficient.

CHAPTER 11 - CONDITIONS ON K WING IN JULY 2019

K Wing

11.1 K wing is a drug dependency wing with a dispensary for administering methadone. The wing is L shaped and on two levels. It houses 128 prisoners in 120 cells, 12 of which are shared. There are 30 cells on each level on each spur.

11.2 In July 2019 there were several incidents on K wing indicating violence or a heightened risk of violence. In previous chapters, we have noted that on 15 July, as well as the injuries to PL, two other prisoners were reportedly assaulted, and on 29 July, when PL was found unresponsive, an ambulance was called to a second prisoner after injuries inflicted during an incident that was recorded on CCTV.

11.3 We note in addition the following incidents reported in the wing observation book

2 July

11.4 A cell window was smashed into the exercise yard; a prisoner called for a shard of glass; another prisoner reported that there were weapons on the wing. A prisoner asked to move wings because he was in debt. He claimed to have improvised weapons to defend himself if anyone opened his door.

4/5 July

11.5 Another window was smashed. Prisoners were searched but nothing found. Information was received that a prisoner had shards of glass in his cell.

11.6 It was reported that three prisoners, under the influence of hooch, threatened to throw other prisoners over the landing railings.

11.7 Two litres of hooch were found in a cell.

11.8 An alleged assault by one prisoner on another. An anonymous note gives the nicknames of two prisoners and says that they and another prisoner have been in a [nickname's] cell tonight threatening the occupant with a blade to rob him. One of the assailants is said to be the one smashing widows and selling all the mamba on the wing.

7 July

11.9 Staff were alerted that there was a broken chair on the wing with a missing leg that might be used as a weapon.

9 July

11.10 An anonymous note asks why [named prisoner] manages to bring drugs in after every visit, and why he and another [named in several of the entries above] are allowed to sell mamba on the wing, and to bully people for their medication and canteen, with nothing done to stop them.

11.11 A prisoner says he is being bullied by a prisoner named in previous entries as responsible for drugs, threats and weapons.

10 July

11.12 A prisoner reported that [a named prisoner] punched him that morning and he was consequently self-isolating.

11 July

11.13 The same assailant was said to be making threats to do whatever he needed to do to go to the seg as he was unhappy not having a television.

12 July

11.14 A cell observation panel was broken.

14 July

11.15 Prisoner Mr Kent was rumoured to be stealing from another prisoner.

11.16 Information was reported that Prisoners Mr Suffolk, Mr Durham and Mr Buckingham were trading in spice.

11.17 Mr Norfolk and Mr Devon were both seen to be watching television in their cells though both were on Basic regime and should not have had in-cell television,

15 July

11.18 Injuries as reported in Chapter 2 to PL and prisoner Mr York. Neither would disclose any information about what happened but, for the injuries to Mr York, CCTV implicated Mr Durham, Mr Norfolk and Mr Chester with Mr Cornwall and Mr Bexley present outside the cell, and Mr Durham, Mr Chester, Mr Devon and Mr Redbridge were overheard by an officer threatening Mr York not to tell.

16 July

11.19 A prisoner transferred from H wing as a self-isolator claims to have been assaulted by four named assailants.

11.20 A prisoner told an ACCT assessment he had self-harmed mainly because of constant bullying by two named prisoners.

11.21 An anonymous note claimed that two named prisoners were bullying for medications and getting people into debt, that they beat up Mr York, and that their bullying was causing people to self-harm.

11.22 Information was received that the assaults on 15 July were due to PL selling hooch he was holding. It was stated that the same group of prisoners were intimidating others and it appeared staff were doing nothing about it. Five prisoners were named with two as the main players. It was said that they were all drunk on the evening of the assaults, barging into people and purposely trying to pick fights. They were said to be getting people into debt, sometimes for as little as a vape, then making them hold things as payback. They were also selling paper falsely purporting to be impregnated with spice to vulnerable or indebted prisoners.

11.23 The record indicates that information known previously about these prisoners was consistent with the information received. All had histories of involvement with drugs, bullying, threats and violence. It was assessed that PL was suspected to have been assaulted due to selling fermented liquid he was holding for other prisoners.

11.24 An entry in the wing log for 22 July refers to a CSIP investigation following an assault on another K wing prisoner on 17 July.

18 July

11.25 A tub containing hooch kicker was found in PL's cell. Information was received that large quantities of hooch were being stored on the wing.

19 July

11.26 An anonymous note asks how [four named prisoners] can get drunk and smash three people's heads in and no officer did a thing. It urges staff to look at the CCTV to see what is happening, and that [one of these prisoners] brings drugs in after every visit. The note suggests someone is covering for him. It also asks why most of these people are on the wing when they are not on the substance misuse treatment programme.

20 July

11.27 The start of a homemade weapon was found in Mr Kent's cell. Mr Kent said he was relieved as he had not wanted to make one but was under threat on the wing.

11.28 An anonymous note names two cells said to have hooch.

24 July

11.29 One of the prisoners said to be involved in assaults and threats to staff and prisoners climbed to the railings complaining about being unemployed. He was aggressive and threatened an officer.

11.30 An anonymous note said [two named prisoners] were bullying another and they 'ruled the wing'. People were rushing people when they were drunk. People were getting addicted to mamba for debt.

25 July

11.31 A prisoner signed the self-isolation policy as he felt unsafe on the wing.

26 July

11.32 Hooch found in a cell.

27 July

11.33 Mr Kent was reported to be brewing hooch in his cell during the night.

11.34 A prisoner wrote to his mother asking for £100 because of a debt said to be owed by his brother and mentioning a threat of hot water and sugar.

28 July

11.35 Hooch found in a cell

29 July

11.36 PL was found unresponsive in his cell

11.37 Assault on Mr Kent. Five named prisoners seen on CCTV assaulting Mr Kent on Spur 1 then pushing him into Cell 18 where they were said to have assaulted him further.

11.38 Information received named three prisoners said to be the main bullies on K wing who 'run everything'. Also that there was an improvised weapon on the wing used by bullies who go into cells and rob people.

31 July

11.39 A prisoner says two prisoners are robbing his cell. Two named prisoners are seen to come out.

11.40 A prisoner tries to assault an officer.

11.41 Safety Intervention Meeting minutes of 12 August show that CSIPs were opened on 31 July on one prisoner, who was moved to M wing, and another, who was moved to H wing. Both were said to have been named as a perpetrator in numerous CSIP investigations and to have been involved in an assault on Mr Kent.

11.42 The minutes of the Use of Force Committee on 12 July 2019 note that H and K wing have been challenging for staff recently. Counselling sessions were to be offered to staff on those wings. It was highlighted that the prison was receiving a lot of new receptions due to the opening of a new wing. This meant H wing was entirely required for inductions and other residents would need to be moved elsewhere, which might meet with resistance.

11.43 It was noted that injuries to staff, and staff requiring hospital treatment, rose substantially from 2 and 1 in April to 8 and 4 in June.

The analysis of instability report – August 2019

11.44 There had been particular problems when the prison opened a new wing in June 2019, increasing operational capacity by 100, and received an influx of new prisoners. An Analysis of Instability in August 2019 says that 244 men were transferred in to HMP Stocken in the previous four months, over 50% of whom were from London and the south-east. This was considered to have had a significant impact in terms of incidents, acts of violence and unrest. 'Requesting a transfer' was the most common reason given by men for participation in these incidents. Many were said to have a prior history of poor behaviour in custody as evidenced by VIPER scores, CSIP referrals and case history. In the 10 most serious incidents in the period 17 July to 5 August, 10 out of 17 prisoners involved were from the recent intake. In August 2019, one-third of Stocken's men now had a history of violence and disruptive behaviour in custody as indicated by VIPER scores.[1]

11.45 Across the prison, during the three weeks from mid-July there were numerous serious incidents in the prison, including a serious cell fire, hostage takings, incidents at height, serious injury to PL, attempted escape, six men barricading in a cell demanding transfer closer to home. There had also been a significant rise in damage to cells and a sharp increase in men claiming to be under threat and debt issues. Safety statistics for June and July indicated a near doubling of some violence metrics.

11.46 The prison was concerned that many of the prisoners transferred in did not fit Stocken's criteria, many were 'complex cases', sometimes individuals were switched for less suitable prisoners on the day of transfer. Prisoners with less than 12 months to serve could not be moved on to resettlement prisons. Some prisoners in Stocken

[1] VIPER is a Violent Predictor risk assessment tool – to assess the risk of an individual's likelihood of being a perpetrator of violence in prison

were frustrated that they had been granted Category D status qualifying them for 'open' prison before release but could not be transferred to resettlement prisons near their home. This was sometimes for lack of transport, sometimes for restrictive acceptance criteria. There were currently waiting times of up to nine months for places at two Category D prisons.

Observations and conclusions

11.47 In June 2019 Stocken prison opened a new wing and received an influx of new prisoners. The Analysis of Instability in August 2019 reports that this contributed to volatility in the prison at the time. (We say more about this below – paragraph 14.6.)

11.48 The challenges faced by staff and by prisoners in daily life on the wings are perhaps too little understood by those who have not experienced them. Stocken is not exceptional. HMIP's inspection of the prison in 2019 rated prisoner safety as reasonably good. Levels of violence were lower than in similar prisons, defying a national trend of increasing violence across the prison estate. The inspectors commended the progress made by a leadership, and many staff, who were highly committed to promoting a decent and rehabilitative regime.

11.49 Yet, one-fifth of prisoners said they currently felt unsafe and 44% said they had felt unsafe at some time. In the six months before the inspection there had been 88 cases of assault – on staff or prisoners – and 27 fights. A quarter of the assaults were serious, some involving weapons and some serious injuries, including broken bones, and requiring hospital treatment.

11.50 In the following chapters we briefly examine the policies in place to reduce violence at Stocken. We also pass on the insights of the people we spoke to during the investigation. In this chapter we make just two observations.

11.51 We commend the diligence of staff on K wing in logging incidents of violence or indicating risk. Sharing this information with colleagues and Security is a vital tool in rooting out violence and keeping prisoners safe.

11.52 Familiarity with the prevalence of violence in prison should not dull our sensitivity to how shocking it is that many prisoners do not feel safe, and experience intimidation and violence. Some but not all victims may also be perpetrators of violence. Violence in prison is neither justified punishment for prisoners' offences nor remotely conducive to rehabilitation. In the next chapter we examine policies to reduce violence. The tagline to Stocken's safety strategy is that safety forms the bedrock of a rehabilitative culture. We agree.

CHAPTER 12 - TACKLING VIOLENCE

12.1. In response to recommendations in the 2019 inspection report, HMP Stocken adopted a phased action plan. This included:

- a needs analysis,
- a strategic drugs policy to focus initially on reducing new psychoactive substances in the prison then, in partnership with Inclusion drug services, to address misuse of prescription drugs,
- a full review by August 2020 of the approach to violence reduction to ensure the strategy and action plan was comprehensive and to address the wide-ranging reasons for violence.

12.2. The daily effectiveness of the strategy would be overseen by a newly appointed dedicated Violence Reduction Custodial Manager and the action plan would be reviewed and updated monthly through the Safer Custody meeting, which would evaluate the prison's performance against national data.

HMP Stocken Safety Strategy

12.3. The strategy was informed by data collected in the prison. A violence reduction survey was conducted among prisoners over the week 14 to 21 June 2019. 73 out of 850 surveys were returned. The prison noted that this was only 8.58% of the population but that nonetheless the responses contained some valuable information towards formulating the Safety Strategy.

12.4. The main reason given by prisoners as a cause of violence was drugs (84%) and debt related to drugs (82%). Other debts were also identified as a cause of violence – community related debt (18%), debt related to hooch (39%) and inherited debt (41%). Frustration was identified by a significant number of respondents as a cause of violence (67%).

12.5. There were 365 incidents of self-harm during the year from April 2018 to March 2019. 13% of the men who self-harmed said it was because they were under threat from other people.

12.6. 49% of respondents reported 'very good' relationships with staff. 29% said it depended on which member of staff. 49% felt staff would help if they reported violence and 70% felt staff would help if they felt unsafe. Some said they would report violence, either to their key worker, wing staff or a wing manager, but 61% said they had never reported violence to staff, with reasons for not reporting being primarily that they did not want to be seen as a *'grass'*.

12.7. From September 2018 CSIP (Challenge, Support, Intervention, Plan) was the case management system for managing and challenging violent behaviour. The data showed a high level of referrals, but few progressing to intervention plans (see below for more about CSIP).

Month	Number of referrals	Number progressed to investigation	Number progressed to a CSIP Plan
July 2019	101	81	4
August 2019	160	138	5
September 2019	110	90	4

12.8. The strategy to improve safety at Stocken prison is based on a framework of '5 Ps' – People, Physical, Procedural, Partnerships, Population. In each case, measures with timed actions are specified.

12.9. People – the right number of staff providing the right level of authority, supervision and support to prisoners, through:

- developing staff capability and wellbeing, including understanding of complex behaviour, risks and triggers,

- reinvigorating the CSIP system, a commitment to maintaining the well-being of staff, through protection including against high levels of desensitisation,

- ensuring sufficient staff to deliver a safe and purposeful regime,

- promoting a rehabilitative culture, through mentors and consultation.

12.10. Population - that prisoners with needs that increase their risk of hurting themselves or others have their needs addressed, through

- weekly consideration of those posing highest risk, and monthly review of the population, to be communicated through staff briefing.

- Applying the national debt framework to understand the nature and scale of prisoner debt at Stocken

- Referral of all men at risk of being in debt, through CSIP and supporting them through intervention/support plans

- review of dual harmers through the weekly Safety intervention Meeting and monthly Safer Prisons meeting

- measures to support young adults.

12.11. Procedural – maintaining strong risk identification and case management processes that challenge but also support the violent and the vulnerable.

- Awareness training, a steering group and senior management monitoring to reinvigorate the CSIP

- Monitoring response to violence through the Violence Reduction Tasking Meeting

- Training for new ACCT version to focus on individual rather than process

- Partnership working with Ambulance Service for contingency plan response from the gate to all wings

- Staff consultation to ensure understanding of emergency codes

12.12. Partnerships – inside the prison and with outside agencies to support safety, through

- Working with Harmless to support dual-harmers and prolific self-harmers

- Exploring new partnerships with outside agencies to introduce training package for safety peer reps to resolve low-level conflict.

Challenge, Support and Intervention Plans (CSIP)

12.13. The CSIP policy is a mandatory national case management system which has been developed as the core instrument for reducing violence in prison. It has been in use since 2018 but the latest guidance is contained in a Safety Toolkit published in July 2022. I have also referred to Stocken's policy dated 2019-20.

12.14. Governor P, Head of Safety at Stocken in 2019, told us that CSIP was introduced at Stocken as a pilot in 2018 before national rollout. She found it a good model that was similar to ACCT (Assessment Care in Custody and Teamwork – the longstanding case management system for prisoners at risk of self-harm) but CSIP was for managing violence and complexities, with input from a multi-disciplinary team to support individuals and put monitors in place, and support for victims if required.

12.15. The policies say CSIP is designed to use existing structures and processes, such as the key worker scheme and offender management, and staff training, for example in using 'FMI', the five-minute intervention aimed at using everyday conversations with prisoners as constructive rehabilitative interventions. CSIP is tailored to the individual, intended to be supportive not punitive and to be a joint responsibility with the individual concerned. It focuses on interactions with individual prisoners, identifying underlying causes, contributing factors, and, in conjunction with the individual, developing a plan to help address their risks and needs and reduce violence in the prison.

12.16. The policy argues that it is too simplistic to say prison violence is caused by single factors, such as drugs or bullying or debt, or imported vulnerabilities or poor relationships with staff. Rather it is caused by multiple related factors involving:

- Individuals who have a tendency to violence
- Non decent environments that leave people feeling uncared for
- Cultural norms that accept violence as a solution to difficulties or a way of establishing respect
- Lack of activity so people feel bored and frustrated and turn to illicit drugs to pass the time
- Interactions with staff where prisoners feel neither treated kindly nor have decisions explained.

12.16. The policy recognises that, whilst violence is often related to the illicit economy it is also related to poor conflict resolution skills. Minor conflicts escalate quickly to violence as the accepted and expected way of gaining respect. With no single cause there is no single solution. Evidence suggests the most effective way forward is to improve prison culture and staff-prisoner relationships. Both staff and prisoners want prisons to be safer places.

12.17. A propensity to resort to violence is said to be associated with the following factors:

Demographic factors	**Background history**
Male Youth socially disadvantaged neighbourhoods Lack of social support Employment problems Criminal peer group	Childhood maltreatment history of violence first violent at a young age history of childhood conduct disorder
Clinical history	**Current context**
Substance misuse Personality disorder Schizophrenia Non-compliance with treatment	Early days in custody and after each transfer Offence particularly those charged with violence against a person and arson

12.18. CSIP aims to apply understanding of the factors driving violence and the factors known to reduce violence, to prevent or reduce the likelihood of escalation in violence and to create an environment that is safe, decent and secure for all.

12.19. The system emphasises: effective use and sharing of information to improve risk management, reduce violent offending and prevent victimisation; enhanced relationships with staff and key workers; and encouraging prisoners to take responsibility for their own behaviour. It focuses on interactions with the individual, developing a plan to help address their needs and risks and reduce violence in the prison.

12.20. The CSIP case management process includes referral, investigation, goal setting and weekly safety intervention meetings. Its purpose is to engage, challenge, work with, support and enable, individuals. Referrals may be made by any member of staff,

prisoner or visitor. Referrals may be made in response to events or to highlight an anticipated risk. A community concern form enables prisoners to make referrals to the safer custody team anonymously.

12.21. CSIP relies on the staff skills developed through existing training for key workers, ACCT case managers, suicide and self-harm awareness, and the five-minute intervention. Staff are expected to use FMI principles in every interaction, that is the 'Five Minute intervention', aimed at turning everyday conversations into rehabilitative interventions, always seeking to identify drivers and to understand. *'Asking 'why' should be the default position before automatically instigating IEP or adjudication processes.'* Case management recording must be balanced, identifying progress as well as setbacks.

12.22. The Safer Custody Team logs referrals and forwards them to the appropriate wing supervising officer and manager to investigate, within 72 hours. The investigation is recorded on a template. The wing manager decides, on the basis of the investigation, whether further intervention is required through completion of an intervention plan, to be compiled in conjunction with the prisoner.

12.23. Wing managers are the case managers for individuals on CSIP plans. Plans should be compiled with the prisoner, exploring the drivers and protective factors identified in the individual case, and setting realistic targets complementary to other processes in which the prisoner may be engaged. All staff having contact with the prisoner must be familiar with the plan and record their interactions on PNOMIS (prisoners' computerised case record).

12.24. The review of progress is a joint responsibility between the prisoner and the case manager. The policy does not specify how frequently reviews should take place but they will not be more often than every 14 days.

12.25. Data gained from CSIP investigations, reviews and intervention are fed into the weekly Safety Intervention Meeting (SIM), Violence Reduction Tasking Meetings and the

monthly Safer Prisons meeting in order to contribute to strategic decisions. These meetings will also take account of other data including the incident reporting system, security information, prisoner complaints, unexplained injuries data, segregation reports, prison and staff focus groups.

The Safety Intervention Meeting and the Violence Reduction Tasking Meeting

12.26. The weekly Safety Intervention Meeting (SIM) is a multi-disciplinary risk management meeting focusing on management and support for individuals classed as posing a significant risk to themselves or others.

12.27. The weekly Violence Reduction Tasking Meeting is a multi-disciplinary risk management meeting focusing on risks across the establishment. It aims to reduce the risks to the prison posed by the behaviour of those in custody; to identify individuals requiring active engagement and support; to provide a forum for multi-disciplinary discussion; to improve information sharing between departments; and to identify those requiring additional supportive case management.

12.28. Governor P told us that the Violence Reduction Tasking meeting provided a single mechanism overseeing, for example, disruption moves in a structured way. The meeting reviewed the previous seven days of violent incidents, prepared for the next seven and considered whether individuals were appropriately located.

12.29. Governor S, Head of Safety at Stocken during our investigation, chairs the weekly SIM meeting and he attends the Violence Reduction meeting whenever he is on duty. He told us he sees his role as promoting an establishment-wide approach to violence reduction, that ACCT processes are appropriately managed, building a rapport with the residential custody managers, and, across the prison, involving Security, Inclusion (ie drug and alcohol support), and residential staff.

12.30. The SIM meeting discusses violent incidents, CSIPs, all prisoners on ACCT, and all in segregation to formulate a plan of safe management, through, for example, reintegration or transfer.

12.31. The Violence Reduction Tasking and Safety intervention meetings are both attended by Security, who can input into, for example, location moves. Governor S told us that there is also good buy-in from the chaplaincy and psychology, and that attendance of staff across all functions, including residence staff shows that the systems are embedded.

Safer Custody and Security

12.32. The current Head of Security, Governor R, was not at Stocken at the time of the incident. She explained the current arrangements for Safer Custody and Security to work together. Each morning Security will go through every intelligence report received in the last 24 hours, in what amounts to a triage process. If there is information about threats, assault or bullying, the security analyst will check that the information has been posted on the computerised case notes of the prisoners involved. In the case of threats or information from men's families, the wing will be asked to do a welfare check. In the case of bullying or threats, if no CSIP has been opened the wing manager will be contacted, Safer Custody are asked to add any additional information, then this is sent back to the analyst.

12.33. Governor R said there is good joined up working between Security and Safer Custody. Security is represented at the Safer Custody Meeting. The Security and Safer Custody analysts meet once a week. There are three security analysts, and one safer custody analyst who attends the monthly security meeting.

12.34. The security department produces a local tactical assessment once a month completed in part by safer custody about violence and self-harm. This identifies rolling threats over the year thus helping resource allocation, though there are insufficient resources to meet requirements – for example the dedicated search team

staff are often redeployed. The assessment also goes to the region and shows hotspots, issues, measures to improve.

12.35. We asked how the work of the weekly meetings changed things on the wing. We were told that the analysis was fed through to wing staff and the analyst would phone the wings to request a welfare check where there was a concern. We were told these practices are now more embedded than in 2019 when they were laying the foundations. Wing managers had become more imaginative about using multi-disciplinary teams.

Observations and conclusions

12.36. It was clear from our investigation that Stocken prison is not complacent about violence. There is a developed understanding of the multiple drivers of violence, and a set of interlocking processes to engage staff from across the prison in working at a strategic level and with individuals to create a safe environment. There is close joint working between security and safer custody.

12.37. The challenge, common to all prisons, is to translate policies into effective practice on the wings. We were impressed by the commitment and enthusiasm shown by staff members we interviewed, and we were told that some of the arrangements that were new in 2019 are now more embedded. But the figures for CSIP investigations in 2019, and some of the comments in IMB reports and from wing staff, give us some cause for concern. We say more about this in Chapters 13 to 15. We note, in particular, the pivotal role of wing managers, who have many other responsibilities. Just as safety is the bedrock of a rehabilitative culture, residential staff in sufficient numbers, skilled, supported, and confident in engaging seriously with prisoners is the bedrock of safety.

CHAPTER 13 - REPORTS OF THE INDEPENDENT MONITORING BOARD

13.1 Reports by the Independent Monitoring Board are detailed and specific. Like the inspection reports, they present a picture of a prison with a sense of direction that has improved over time.

2018-19

13.2 The IMB report for 2018-19 notes that the Governor has made it a major priority to reduce the availability of drugs, particularly so-called 'new psychoactive substances' (NPS). A policy of photocopying incoming mail (except that covered by legal privilege) caused a sharp fall in the number of men judged to be 'under the influence' of illicit substances. The prison additionally had acquired equipment to test unopened mail, which revealed that some supposed legal correspondence was contaminated. Another source appeared to be staff corruption, and several individuals had been identified whose cases had been passed to the police. Two predictable consequences of this success were that the price of psychoactive substances had rocketed, unfortunately creating the acquisition of huge debts by the most addicted prisoners, and an upsurge in the brewing of alcohol.

2019-20

13.3 The report for the year May 2019 to April 2020 commented that the introduction of CSIP was slightly uneven. In early November 2019, not all staff were making referrals in a timely fashion or at all and the safer custody team was having to go through the daily briefing sheet to check on violent incidents and chase staff for referrals. Also, reviews were not optimal. It was proving hard to assemble interdisciplinary teams.

13.4 Minutes of the weekly Safety intervention Meeting indicated in the early part of 2020 that an increasing number of cases were being postponed sometimes repeatedly. The Board raised this with the Governor, who was already addressing it. He ascribed it at least partly to increasing demands on assistant governors.

13.5 The number of prisoner-on-prisoner assaults fell from 153 in 2018-19 to 132 in 2019-20, of which 21 were judged serious, compared with 30 the previous year. Numbers had fallen sharply following lockdown for the Covid pandemic.

13.6 There were 79 prisoner assaults on staff, of which 18 were judged serious. The previous year's figures were 80 and 17. There was no comparable reduction of prisoner assaults on staff in lockdown.

13.7 In January 2020 there was an outbreak of concerted indiscipline affecting a whole spur on M wing after a serious assault on an officer and his rescue by colleagues. Subsequent investigation revealed that the number of ringleaders was small, they were largely from London and the south-east, and trouble had been brewing for some weeks with prisoners on another wing, who were also from outside the area, involved in the planning and instigation.

13.8 One of the most radical changes during the reporting year was a very sharp drop in the availability and use of psychoactive substances, which was understood to be extraordinarily low in comparison to comparable prisons. Success was attributed largely to the testing of correspondence.

13.9 Again, the scarcity of psychoactive substances had increased its price, incentivising organised crime groups to target prisons since the price in prisons was far higher than in the community. This had encouraged organized crime groups to try to infiltrate prisons, through corrupt staff or, mainly, through transfers from remand prisons, with consequent debt problems and intimidation of family members if payment was not forthcoming.

13.10 As in the previous year, the reduction in supply of psychoactive substances had led to a large increase in illicit brewing of alcohol. Measures were in place to detect this and the Governor had reduced the availability of the raw materials, in particular fruit, which was limited to one piece a day on request.

13.11 In relation to the IMB's responsibilities to monitor the use of segregation the report notes that paperwork was often late or inadequate for Rule 45 reviews, or where Regional Director's authority was required for a prisoner to be held in segregation for more than 42 days.

13.12 An external health needs assessment in October 2020 compared HMP Stocken to five similar prisons. Stocken had the highest reduction of methadone use and was seen as an example of best practice across the estate.

Observations and conclusions

13.13 In PL's case CSIP referrals were made on three occasions before 29 July. Each time, there was a brief investigation, but none proceeded to a plan. In the case of his injuries on 15 July, the CSIP referral was closed because PL was unwilling to disclose any information. After his collapse on 29 July, he had no capacity to do so. Consequently, we have not seen evidence of the effectiveness of CSIP planning in action and are not in a position to evaluate it. However, in the next chapter we report what staff told us about it. Our impression from this, from the IMB reports, and from the data, is that it takes time for the system to become embedded and we are uncertain how far that process has progressed to date.

13.14 The IMB report gives an impressive and detailed account of how the prison has been working to reduce the pernicious presence of new psychoactive substances. This is consistent with what we learned from witnesses. The report also notes the tenacity of the challenge drugs present: reduce the supply of drugs and the value - and the stakes - go up; and illicit alcohol increases to take its place.

13.15 Unfortunately, as noted by the IMB, one of the ways that drugs get into prison is that they are brought in by corrupt members of staff. Stocken has been rigorous in aiming to eliminate this. A former member of staff was sentenced in October 2021 for trafficking Class B drugs into the prison and we are aware of other cases where no conclusive evidence has been found but staff have been suspected and have abruptly left their jobs. The Governor expressed his determination to work to eliminate

corruption and the Head of Security expressed her regret that Stocken had been unable to obtain funds to enhance front gate security.

CHAPTER 14: WHAT STAFF TOLD US ABOUT VIOLENCE AT STOCKEN PRISON

Introduction

14.1. In May 2022, we spoke with wing officers, custodial managers, a representative of the Prison Officers' Association, the governing Governor, heads of functions, the Chair of the IMB and two prisoners, both of whom were Listeners. Without exception, the people we spoke to said that Stocken did not feel like an unsafe prison. Several of our witnesses commended the management of the prison, and the security systems, and we were impressed by the commitment and thoughtful engagement of the people we interviewed. In this chapter we record what we were told by staff and by the IMB about some of the issues raised in this investigation. In the next chapter we say what we were told by the prisoners we met.

K wing

14.2. We were also told that K wing was one of the quieter wings and witnesses did not recall any exceptional difficulties on that particular wing in July 2019, although it was a difficult period in the prison after the opening of a new wing. K wing was smaller than the main residential wings and many of the prisoners were said to be drowsy as a result of prescribed methadone.

14.3. However, two staff members said that prisoners on methadone were vulnerable to exploitation by stronger characters on the wing who were mostly not on the substance misuse treatment programme. We were told that it was not practicable to confine K wing exclusively to prisoners on the treatment programme. There were not enough of them for the 120 cells on the wing; and some prisoners who were on the programme had to be located elsewhere for security reasons.

14.4. Many of our witnesses spoke of the pernicious effect of illicit drugs, especially spice, and also hooch, leading to debt, threats, which could extend to prisoners' families in the community, and intimidation.

14.5. Gang affiliations were also seen as a factor, and jockeying for position among prisoners newly transferred to Stocken and not known to the staff there. Stocken receives prisoners from all over the country. We were told that some are disruptive to try to get a transfer closer to home.

Population changes – the instability report August 2019

14.6. In Chapter 11 we referred to the analysis of instability that occurred from June 2019 when Stocken opened a new wing. Stocken is due to open another new wing in 2024. We were told that a large influx of prisoners transferred from elsewhere always brings volatility as pecking order and informal 'rules' are established. In the view of the Governor, this needed to be managed strategically, through over-staffing at first, flooding the wing with experienced staff by buying extra and freeing up others, if necessary by relaxing other targets.

CSIP

14.7. Officers who had worked on the wings were aware of the CSIP system and had made referrals but told us that investigations were conducted by managers and there was no feedback. *'If there was an assault you just put in a CSIP about what happened and it goes to the Custody Manager who deals with the rest.'* A key worker told us that in 2019 their understanding was that they should tell the supervising officer, who would raise a CSIP. Now they were more used to it and understood that anyone can raise a referral, which goes to Safer Custody who will speak to the individual concerned.

14.8. A former wing officer had a clear memory of many of the prisoners who were on K wing in 2019 and their behaviour on the wing. This officer told us that the structures in place for tackling violence made it difficult to act swiftly to nip issues in the bud. They said that it used to be possible for supervising officers to be able to arrange wing moves with the supervising officer on another wing. Sometimes this would give a prisoner a fresh start and they'd *'turn around'* because they needed a change of environment. Under the new policies, it all had to go to meetings, they would be

waiting a few days and something else would happen with the same prisoner, which had to go back to the meeting and be taken into account.

14.9. CM K told us that CSIP had the potential to be great, but they had insufficient resources to run it as effectively as they could. Having worked in offending behaviour programmes, Mr K saw the potential to build on thinking skills work in one-to-one sessions as part of intervention plans. But in practice, there would be an incident, a staff member would put in a CSIP, it would be investigated by the wing supervising officer who has many other responsibilities and is trying to keep on top of their workload. So they have a quick chat with the prisoner, type it up and it loses its effectiveness.

14.10. Governor S, Head of Safety, attached importance to CSIPs being personalised and not generic. They had recently developed more linkage with prison offender managers and key workers. They had not been able to do this effectively during Covid restrictions. Consistency of key worker was important, especially for prisoners with complex needs so that they were not expected to repeat information to several different people. In cases of self-harm, they tried to put key workers as part of the safer custody team to build a rapport and they sometimes tried to do the same with cases of violence.

14.11. CSIPs are used for perpetrators, victims, prisoners who self-harm or who are otherwise vulnerable, and for antisocial behaviour. For prisoners transferring in, they do pre-emptive checks including VIPER scores and speak with them at an early stage about expected behaviour.[1]

14.12. Mr S told us the statistics indicated some success. Ideally, they would have ringfenced officers on duty each day with the same four officers doing most of the investigations. One reason why victims were unwilling to say what happened to them was threats made to their family. The Violence Reduction Tasking meeting discussed proposed

[1] VIPER is a Violent Predictor risk assessment tool – to assess the risk of an individual's likelihood of being a perpetrator of violence in prison

wing moves. Some prisoners had a habit of running up debt then running to segregation. The prison tried to build skills through offender management, education, and money management courses. Recently they had introduced new courses, including Kaizen, an accredited offending behaviour programme, and STARS, a well-being programme that was thought to have radically reduced self-harm. Men completing the STARS programme were used as mentors. It involved mediation, relaxation, etc, which were seen as alternative kinds of therapy taking the place of spice.

14.13. Head of Security, Governor R, was appointed recently and was not at Stocken in 2019. Governor R had found some lack of knowledge among staff about CSIP. Even if a victim was unwilling to disclose information, that did not mean that they should not be supported. Also, if a fresh incident occurred there needed to be a fresh investigation to examine the cause of the latest incident. It was theoretically a good scheme but hard for custodial managers to navigate. There had been little training.

Unexplained injuries

14.14. We asked staff what could be done about unexplained injuries when prisoners were unwilling to say what happened for fear of reprisals.

14.15. Officer C said that unexplained injuries were not common but if a prisoner would not say what happened there was little you could do unless there was CCTV footage. Officer C said staff could try to probe, but prisoners didn't want anyone to know they were talking to you. Officers could only put in a security report.

14.16. Custodial Manager H explained that custodial managers are responsible for an area or department with up to 18 staff and their prisoners. When a CSIP is submitted there is an investigation but if the prisoner did not want any involvement then the case is closed though the threat may still be there.

14.17. Custodial Manager K said if someone was guilty of an assault they should be dealt with accordingly but it was very difficult if there was no supporting evidence. Also, even if a prisoner was a victim, staff have to take into account that they may get further victimisation if they are labelled as a grass. There were communications networks between prisoners, so even a transfer out would not necessarily protect them – '*though it sounds wrong, you have to take account of the rest of their sentence.'*

14.18. The POA representative saw rapport with trusted staff as key to victims disclosing information though they were never going to be able to solve the fear of reprisals completely. Prisoners had to believe that if they disclosed information action would be taken, but even a move might not be sufficient to protect them.

14.19. Governor P said that if a victim was unwilling to disclose what happened, then, like the police, they would close the case, but Safer Custody and security analysts would pick up information if there was a continuing risk or other cause for concern. The analyst would phone the wing, explain the reason for concern and for example might request a welfare check. The Safety Intervention Meeting could continue to monitor.

14.20. Governor R said they were aware that some victims feared threats to themselves or their families. There was coercion involving debt, drugs, phones, money, not just assault.

What causes violence and what reduces it

14.21. Custodial Manager K commented that every prison has violence but Stocken is one of the less violent on comparative data. Violence can stem from drugs, especially spice, leading to debt. There are also gang issues. Staff may not be aware of gang issues when new prisoners arrive. Spice and rival gangs are the main causes.

14.22. We were told that Stocken had a good record in reducing supply of drugs, They used a rapiscan machine to check mail and had introduced a barcode system for legal letters. It was noticeable if a batch of spice was circulating in the prison, if, for example, there

was a cluster of 'under the influence' picked up at roll check. Then debt problems would follow a few weeks later. They used searches for men going off the wing, and staff searches. People who genuinely wanted to stay off drugs were located on I wing, the drug-free recovery wing. As far as possible those taking part in the substance misuse treatment programme were located on K wing.

14.23. Being far from home could encourage violence. People 'acted out', in the hope of getting a transfer.

14.24. Factors that reduced violence were: staff working with prisoners and building a rapport - Mr K said that when he joined the Prison Service there was time to do that but that was not quite the case now; resettlement: having an address to go to; support to get a job on release; a bank account - setting the men up so they don't feel they go out to nothing, which encourages crime in order to come back.

Staffing

14.25. Many of our witnesses spoke of the critical importance of having enough experienced, confident staff who knew how to build a rapport with prisoners. Staffing levels had been reduced in recent years. The Governor told us that the 2013 benchmarking exercise which reset staffing levels resulted in the loss of 27-30% experienced staff to voluntary early departure.

14.26. A POA representative told us that there continues to be a problem with staff vacancies and experienced staff leaving. Reasons for leaving were shifts, pay, staffing levels. If staffing shortages mean they struggle to deliver the full regime and many prisoners are locked up more that can have a bad effect. He understood that at a rate of 14% of staff leaving each year Stocken's figure was not especially high, but recruitment was difficult. Stocken is in a relatively affluent area. There are no major cities close by, and several prisons competing for staff.

14.27. The Head of Safety said staff might drive as many as 30-40 miles to work and were affected by increases in the price of fuel.

The regime

14.28. Witnesses spoke of the importance of purposeful activity in reducing violence.

14.29. Opening up the regime again after the constraints of the Covid pandemic lockdown had enabled a 'reset'. There were now more structured activities, and smaller groups in work and education, but the prisoners had less time out of their cells than before the lockdown. The main wings normally had two spurs each with two or three landings. In the morning one side would go to work or education whilst the other side had their domestic period. In the afternoon they changed over. This rotated weekly. Then in the evening they would have Structured On-wing Activities (SOWA) with limited numbers of prisoners taking part each day.

14.30. The new arrangements were introduced only shortly before our interviews. Staff were generally enthusiastic and believed they would continue to drive down violence. Officer A contrasted the time before Covid when there were more alarm bells and more violence when the men had more time out of cell. Now they were out less and with structured activities in the evening they were all occupied and didn't have all day to get bored.

14.31. Governor P said the wings felt different in the evening with structured activities and she saw staff and prisoners engaging together.

14.32. Governor S, Head of Safety at the time of our investigation, said that before Covid there could be 200 men on a wing out on a Saturday afternoon with no meaningful activity except visits and gym for some. The new system of structured on-wing activities (SOWA) gave more structure and safer numbers. In forums, prisoners said they preferred it. In Covid forums, representatives discussed safety and violence.

They said they felt , and Stocken's statistics are leading among comparator prisons. SOWA enabled meaningful time.

14.33. We asked whether the new 50:50 regime was a device made necessary by Covid or a good thing in itself. The POA representative thought it was a bit of both. Covid caused a reset. They were struggling to staff the new regime, but it was a good thing, providing additional time out of cell, incentivising prisoners to behave better, and enabling staff to sit and interact with prisoners in the way that used to be possible.

14.34. The Chair of IMB commented on the value of having smaller groups in work and education. Instructors could give the men more one-to-one attention. Many of the men had very little experience at any time in their lives of one-to-one engagement with someone who would listen to them.

14.35. There were some reservations about the new regime. The Head of Security commented that the 3.5 hours' time out of cell for domestic activities was a long time for shower and exercise. With in-cell phones the men no longer needed to be out of cell for phones. Structured activities took place only in the evening.

14.36. One of the prisoner Listeners we spoke to liked the 50:50 regime. He was doing a degree, and told us he was happy to be able to get on with his studies in his own room, but it was a struggle for many men who found it hard to be behind their doors and wanted to be out on the wing.

14.37. The other Listener said he remembered when there was work or education all day and in the evening you would shower, make phone calls or do other activities. The day was full, but now many people were bored for half the day. SOWA was for prisoners on enhanced regime but didn't help the non-enhanced. They had to occupy themselves for a massive period in the afternoon. He felt that general association had been knocked on the head because the prison couldn't staff it.

14.38. The Head of Safety told us that new offence-related courses, such as 'STARS' and 'Kaizen' focused on well-being and reducing stress, anxiety and depression through alternative kinds of relief to taking spice, and it had radically reduced self-harm.

Observations and conclusions

14.39. We were privileged to be able to talk with witnesses about their perceptions of what makes for a safe and healthy prison. The comments recorded in this chapter largely speak for themselves. There is general consensus about the drivers of violence and what helps to reduce it. Issues to which we draw attention are the views expressed by officers that suggest that they do not feel fully engaged in the CSIP process, and the way in which an influx of a large number of prisoners can cause volatility. We note that the Governor hoped to be able to take preemptive measures when Stocken opens a new wing in 2024.

14.40. A constant theme is the importance of staff engaging constructively with prisoners. Stocken's Safety Strategy relies, among other things on *'the right number of staff providing the right level of authority, supervision and support to prisoners'*. As part of this investigation, we had cause to review several hours of CCTV footage of K wing on the day of PL's collapse. We were struck by the relative absence of staff during the morning, when prisoners were unlocked and out on the wing. Some prisoners were busy with laundry or cleaning, but many prisoners congregated in groups, with others coming and going, seemingly with little staff awareness, and little evidence of staff interest as they passed through the wing. It is beyond the scope of this investigation for us to take a view on the new 50:50 regime, about which staff spoke enthusiastically, but structured activities involving staff and prisoners, coupled with a culture of active curiosity by staff, treating prisoners as individuals, can only be helpful.

CHAPTER 15 - WHAT THE PRISONERS TOLD US

Introduction

15.1. We spoke with two prisoners at Stocken about their perception of violence in the prison. Both had experience of other prisons. Both were Listeners and currently located on the drug free wing.

15.2. They said debt was not just about drugs. Vapes, medication and all kinds of possessions had value for bartering in the illicit market on the wings. Many prisoners had problems. Some were particularly volatile, and within the pressured atmosphere of the prison could react violently to frustrations, such as a cancelled visit; or they might take an apparently irrational dislike to a fellow prisoner. But violence didn't involve everyone. It was a small minority of people, and it was sporadic.

Debt and canteen

15.3. The days when canteen was issued were a hotspot. Debt was a major cause of intimidation and that was often when prisoners would call in debts. Many prisoners got into debt to others. For example, four vapes could cost as much from canteen as a week's prison wages and the convention was often that debtors were required to pay back double the loan – two vapes for one.

15.4. From their wages, prisoners also had to pay for PIN phone credits and other incidentals, like toiletries. Wages varied in the prison but even those on higher wages would get into debt if they were not good at waiting for what they wanted. Debt would not necessarily lead to violence immediately, as the lender wanted to be paid, but it meant the debtor could be manipulated or threatened.

15.5. The prisoners were emphatic that the main key to reducing violence was more vigilant staff who were experienced and visible on the landings, staff who knew how to read behaviour and situations and to talk with prisoners.

15.6. For example, on canteen day, staff needed to be aware of the culture of debt and to show by their presence they were in control. The prisoners had known different systems of distributing canteen. It was preferable that it was done privately – cell by cell or in another room rather than in an open line where everyone could see what others were getting. Prisoners would move stuff from cell to cell even though it was supposed to be against the rules. A prisoner might have bought large quantities in canteen but then have little in his cell. Staff needed to be alert and aware and to enforce the rules about not passing property on to others, whereas instead they colluded with it if a prisoner asked.

Key workers and wing staff

15.7. The prisoners were doubtful about the value of key workers. They preferred the former system of personal officers who worked on the wing where the prisoner lived. That meant there was more contact, good officers were more aware of the context of the wing, they got to know their allocated prisoners through daily interaction, and would notice any changes in mood or behaviour. Key workers could help with practical issues but probably did not know their prisoners well enough to coach them. The prisoners were full of praise for some particular experienced officers. Their qualities were that they got to know the prisoners, took trouble to know their sentences and prospects, they were clearly observant about what was happening on the wing, they were approachable, and they knew how to talk to prisoners.

15.8. The prisoners had seen a reduction in staffing and found that many of the staff were now inexperienced, lacking confidence and skill to engage effectively with experienced prisoners.

The Listeners and peer support

15.9. The prisoners told us about their experience as Listeners. They found some officers were suspicious of Listeners' motives and did not understand or respect their

obligation of confidentiality, which is just like the Samaritans. They suggested the Listeners could contribute to the induction of new staff.

15.10. One instance of good practice was when a supervising officer on one wing had engaged them to help, after some prisoners died on the wing. Instead of putting a note under cell doors, an officer went round the wing accompanied by a Listener. Prisoners were handed the note and offered the opportunity to talk to a Listener. He told us it was striking how some men had found it hard to speak to staff. The officer would ask a question and the man would reply to the Listener.

15.11. At one time, Listeners had sent a representative to part of the managers' operations meeting but that had stopped when it moved to a board room where they were not allowed.

15.12. Recently, Listeners had been included in reception procedures for new prisoners. They were willing to do this but thought that the role could have been fulfilled by 'Insiders', as most of the people they spoke to wanted a general chat about the prison. Stocken does not have Insiders.[1]

15.13. One of the prisoners had a mentoring role for other prisoners on his wing. Being experienced in how things worked, he could help, for example, with filling out applications and use his Listener skills. However, he understood there was no longer a course to become a wing mentor. Nor were there Lifer representatives any longer. The prisoners understood that this was because of the number of prisoners with IPP sentences, but, in their view, the needs of IPPs and other Lifer prisoners were different.[2]

[1] Insiders are prisoners recruited to provide peer support, especially to new prisoners.

[2] IPP – indeterminate sentence for public protection were available to the courts to impose from 2005 until they were abolished in 2012. Prisoners sentenced to IPP are released only when they are considered no longer to cause a serious risk of causing serious harm through further serious offences.

15.14. The prisoners had the impression that, with fewer staff to supervise, the prison did not want so many people out of their cells in these various capacities. In the prisoners' view this was wasting a resource.

The 50:50 regime

15.15. The two prisoners had different views about the 50:50 regime. One of them who was working for an academic qualification appreciated the opportunity to work in his cell for half the day. The other felt it was generally unpopular, as prisoners spent half the day behind their doors without activities. Structured On Wing activities (SOWA) was only available for enhanced prisoners.

Observations and conclusions

15.16. As in the previous chapter, the Listeners' comments largely speak for themselves. Issues to which we draw particular attention are their views about the pervasiveness of debt, which is not confined to drugs, supervision of canteen, the role of the Listeners and other forms of peer support, the different needs of IPP and Lifer prisoners, and the profile of the staff members they particularly respected. The pros and cons of dedicated key workers who do not work on the wings of their allocated prisoners are frequently mentioned in discussions of this kind.

APPENDIX: THE INVESTIGATION PROCEDURE

Article 2 of the European Convention on Human Rights

1. I am required to conduct the investigation in compliance with Article 2 of the European Convention on Human Rights. Article 2, which safeguards the right to life, and can require the State to mount an independent investigation when someone in custody suffers life-threatening harm.

2. In compliance with Article 2, the investigation will be independent, open, transparent and even-handed, and will provide an opportunity for PL, or those who can represent his interests, to participate in the investigation.

3. My objective is to ensure as far as possible that the full facts are brought to light and to identify factors that can be shown to have caused or contributed to PL's injury.

4. The investigation will not consider any question of criminal or civil liability.

The investigation team

5. I will be assisted in the investigation by Andy Barber, as Assistant Investigator, and by the Article 2 Secretariat.

6. The investigation may commission a suitably qualified health professional to provide clinical advice.

The investigation process in outline

7. The investigation will examine documents, establish relevant lines of inquiry, prepare a chronology, and identify relevant witnesses. Interviews with witnesses will be held in private. They will be recorded and transcribed. Documents and transcripts will be made available to the interested parties in confidence to enable them to participate in the investigation but they will not be published. Documents and interview transcripts may be quoted or referred to in the investigation's final report, which will be a public document and will be made available on the website of the Independent Advisory Panel on Deaths in Custody. Unless there are exceptional circumstances, individuals will not be named in the final report.

8. The investigation wishes to consult PL or his representatives at an early stage as to how PL's interests may be represented in the investigation.

9. Introductory visits and meetings may also be held with others, including the other interested parties.

The interested parties

10. The interested parties known to the investigation at present are PL, Her Majesty's Prison and Probation Service, NHS England and NHS Improvement, and Practice Plus Group which provides healthcare at HMP Stocken.

11. Anyone else who considers they have a special interest in the proceedings or outcome of the investigation may ask me to consider granting interested party status.

Evidence

12. The investigation requests interested parties and anyone who holds documents that may be relevant to supply those documents to the investigation. The investigation may request further documents and/or oral evidence from the interested parties or other persons whom it considers hold relevant material.

13. The investigation makes a presumption that relevant documentary and oral evidence will be shared, in confidence, with interested parties, and with others where that is necessary for the conduct of the investigation. However, there are some circumstances where, exceptionally, documentary evidence may be redacted or withheld.

14. The terms of the investigation's commission stipulate that the Secretary of State may require redaction of documents on the basis of security, relevance or other sensitive matters before onward transmission to interested parties or others.

15. Where a witness or any other person considers that any part of a document, transcript, statement or other material they have provided should not be disclosed, he or she should inform the investigation of the reason for this view when the document or statement is provided.

16. If any material that the investigation considers relevant is redacted by the Secretary of State or withheld at the reasonable request of a witness, the investigation will disclose to the interested parties the fact that material has been redacted or withheld and the reason for this.

17. The investigation may undertake interviews with witnesses it considers relevant. Witnesses will be provided with a written explanation of the investigation, terms of

reference and the purpose of the interview. The investigation will have regard to the need for witnesses to have the means and opportunity to obtain support and representation if necessary. All the persons approached will be directed to the issues about which it is considered they may have relevant evidence. They will be supplied with copies of documents that are relevant. Interviews with witnesses will be recorded and transcribed.

Draft report

18. The investigation report will be made available in draft to the interested parties, in confidence, so that any factual inaccuracies may be addressed and any comments considered before final submission to the Secretary of State.

19. Any person who may be criticised in the investigation report will be given advance disclosure of the criticisms and be given the opportunity to respond before the report is finalised.

Final report

20. The investigation report will be presented simultaneously to the parties, subject to appropriate redaction if necessary. It will be a public document and will be published on the website of the Independent Advisory Panel on Deaths in Custody but without the documentary and witness evidence.

21. The final report will not contain the proper names of any persons unless the investigation considers that, exceptionally, any individuals need to be named for the purposes of Article 2, for example, because that person has been involved in serious wrongdoing. If I am minded to name any individuals in the report for this or other reasons I am required to write to the Secretary of State in advance giving reasons.

Barbara Stow
Lead Investigator **31 August 2021**