

**The Murder of a Man by his Cellmate on 2 April 2004  
whilst in  
the Custody of HMP Leeds**

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

**October 2005**

## **Foreword**

The murder of a man by his cellmate in Leeds prison on 2 April 2004 was the very first death in custody referred to my office after I took responsibility for all such investigations. In the event I have conducted probably the longest, and certainly the most extensive, investigation of any death ever to have occurred in a British prison.

Throughout the investigation, I have endeavoured to engage the man's family and their legal representatives. I first met with members of the family in the immediate aftermath of the man's death and I pay tribute to their decency and compassion in the face of the tragedy that overtook them. I offer here in public what I have said in private: my sincere condolences of the loss of their beloved family member. Theirs is a close-knit family, and the man is mourned as a son, brother, husband and father.

The family has had many questions about the circumstances that led to his death. I have endeavoured to answer all those questions – an endeavour that explains in part the great length of this report. However, I am conscious that some of my answers may not satisfy family members and few offer any comfort.

I am also aware that the family has been dissatisfied by my reliance on investigators employed by the Prison Service. In a letter from their solicitors dated 10 August 2004, I was told that "the family has no confidence in the investigation process because Prison Service personnel are carrying out the interviews". A similar message was expressed at my final meeting with the family in April 2005. At that meeting, I was also asked to bring this investigation to as speedy a close as was possible, the family wanting me to do nothing that might delay the forthcoming inquest. I have followed that advice. This final report has been amended from earlier drafts to reflect comments from the family, the Prison Service and the Commission for Racial Equality.

In view of the family's concerns, it may be helpful to explain here exactly the way in which this investigation has been conducted. The announcement that I was to become responsible for the investigation of all deaths in prison custody was made at the beginning of January 2004. Given a start date of 1 April, it was clearly impossible for me to recruit, train and induct the number of new investigators I would need. I therefore agreed transitional arrangements with the Prison Service whereby I could call upon the Service's trained investigators and senior investigators who would work under my overall direction. In practice, this system worked extremely well and I am greatly indebted both to the individual staff concerned and to the Prison Service as a whole. That said, I was pleased when the transitional arrangements came to a close on 30 November 2004.

In the case of this investigation into the murder of the man who is the subject of this report, I have every confidence in its thoroughness, rigour and impartiality.

Indeed, I am proud of the extent to which the investigation has established new standards on the disclosure of information to the family (something I believe is both right in itself and necessary in terms of the investigative obligation upon the state under Article 2 of the European Convention on Human Rights). In light of the family's observations, witnesses have been re-interviewed and documents repeatedly assessed. In addition, the findings of the investigation team have been scrutinised by one of my most experienced colleagues and investigators. Significant amounts of further information have been requested and further interviews undertaken under her direction. This report has been written entirely by myself and members of my independent office.

The original Terms of Reference for this investigation set the objective of establishing the circumstances and events surrounding the man's death. I met his family in June 2004 to discuss progress and initial findings from the investigation. I agreed at this meeting to widen my terms of reference to include an incident that occurred on 11 March 2004 when the man ended up in the segregation unit. The family was concerned that this incident was connected to the tragic events of 2 April and I agreed to try and establish whether this was so.

West Yorkshire police conducted simultaneous investigations into the murder of this man and the incident of 11 March. They too looked closely at the decision to allocate him to the cell on A wing where he was killed and any link with the events of 11 March. A protocol was quickly established between the police and my team and a significant amount of information was shared between the two investigations. I have also received from the Coroner a copy of the entire police evidence. No charges, save for the charge of murder against the defendant, were made as a result of the police investigation.

During the course of the past 15 months, some 120 people have been interviewed and over 200 documents have been examined and considered. Other issues emerged that, though not necessarily of direct relevance to the murder of this man, are important outcomes of the investigation. I have been particularly concerned to look at Leeds's approach to issues of diversity and race. I have considered these under the heading 'The management of race issues' at Annex B. It does not make happy reading.

I also received from the man's family's solicitors other documentation relating to the handling of prisoners' complaints at HMP Leeds and a copy of a dossier, subsequently investigated by the Prison Service, alleging more systematic discrimination against black and Asian prisoners. It has been accepted that neither the documentation nor the dossier were directly relevant to the circumstances of the man's murder, and given that they have been addressed elsewhere, I make no further reference to them in this report. However, given that the man was an Asian man murdered by a white man, issues of race have never been far from my mind.

I am most grateful to members of the investigation team for their efforts on my behalf. The team was led by the former Governor of HMP Hull, very ably assisted by the Intelligence and Investigations Manager for the Yorkshire and Humberside Area Office and the Head of Custody at HMP New Hall.

I also wish to acknowledge the ready assistance I have received from the West Yorkshire police, in particular by the Detective Superintendent, the Detective Inspector, the Detective Constable and the Family Liaison Officer.

This report considers in detail the circumstances that led to the man who died and the defendant being placed together in a cell on A Wing. A particular focus is upon the system of cell sharing risk assessment (CSRA) as it applied to the defendant. The information upon which staff at Leeds based their decision was extremely limited, and I am particularly concerned that the situational aspects of the defendant's previous violence were not identified. A later warning about the defendant from a probation officer was not acted upon. My office has shared views on CSRA with the Zahid Mubarek Inquiry.

I am conscious of the pressures placed on staff at Leeds and other local prisons given the size of the prison population. All cell sharing necessarily carries some risks. Those risks are magnified by levels of overcrowding and turnover ('churn') on the scale that obtains at Leeds. I note that the Annual Report of the prison's Independent Monitoring Board explicitly draws attention to the strain this places on prisoners and staff alike. The Board refer tellingly to "the tacit acceptance of overcrowding". Overcrowding undermines the ability of the Prison Service to provide individual care of those in its charge and significantly increases the risks posed by violent offenders to their fellow prisoners. I expressed my concerns when I investigated the murder of another man. The man who is the subject of this report died in similar circumstances only seven months later. In this report, I draw attention to aspects of the cell sharing risk assessment process in general and as specifically applied to the defendant's. The imbalance between the number of prisoners and the number of reception staff expected to make the assessments can only serve to overburden and diminish the effectiveness of the risk assessment process.

I also consider the prison's response to the attack on the man who is the subject of this report. I am particularly impressed by the compassion and professionalism shown by the member of staff and the nurses who were (in the Prison Service's rather antiseptic jargon) 'first on scene'. The clinical review draws attention to some important areas where improvement in practice can be made. I thought the notices issued by the Governor were sensitively worded, and he gave conspicuous leadership by returning to the prison from commitments elsewhere and remaining in the jail over the weekend immediately after the murder. I was also pleased to learn that the Director General of the Prison Service had sent a personal letter of condolences to his wife.

However, other aspects of family liaison were much less well handled. The family remain angry at the delay in informing them of what had occurred. I share their concerns.

The defendant and the man shared a cell together for around 30 minutes on that fateful morning in April 2004. What exactly happened during that time I cannot say. What I do know is that the victim was a young man who died of horrific injuries while in the care of the state. He leaves a large, loving family including a wife and two young children.

**Stephen Shaw**  
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## **PART ONE: The murder of a man and the circumstances surrounding it**

### **Section 1: Background**

#### **HMP Leeds**

Leeds is predominantly a Victorian prison. The four original wings (A, B, C and D) were built in 1847. Two further wings (E and F) were opened in 1994 together with new kitchens, gymnasium and Healthcare Centre.

Leeds is a category B local prison accepting adult male prisoners from West Yorkshire. It has 680 cells on the main wings and has space for up to 55 prisoners in the Healthcare Centre.

The man was murdered on A wing. A Wing consists of four landings. The bottom landing, A1, also contains the segregation unit which is known as S1. A1 is used for the dirty protest cells, the cleaners and "overflow" from the segregation unit. The two areas are separated by a metal gate, which is generally left open. Segregation unit staff decide which prisoners are located on A1.

A wing was used to house the vulnerable prisoner (VP) population until 2003 when most of the VPs were transferred to a new unit in HMP Hull. It was intended that a few VPs on trial at courts in Leeds would remain on A wing. On conviction they would be transferred to Hull. When spaces at Hull became restricted, A wing became a hybrid wing with VPs populating the outer part of A2, A3 and A4 landings, and 'normal location' prisoners occupying the cells on the inner part of these landings. Staff tried where possible to keep one empty cell between the VPs and the other prisoners. The two regimes ran separately and the number of cells occupied by VPs fluctuated with the VP numbers. In April 2004, 'normal location' prisoners occupied cells on A2 and half of A3 and VPs occupied cells on half of A3 and all of A4. A wing is now once again entirely populated by VPs.

Her Majesty's Chief Inspector of Prisons (HMCIP) undertook an unannounced inspection of Leeds between 30 June and 4 July 2003. The report commented that Leeds presented as a typically overcrowded and pressurised local prison. At the time of the inspection Leeds held 60 per cent more prisoners than it was designed for, and almost all of them were two to a cell designed for one. In one month over 400 new prisoners had to be settled into the prison. Reception staff dealt with 150 prisoner movements a day in "cramped and unsuitable conditions". The average stay for a prisoner was 12 weeks.

In March 2004, Leeds was still 52 per cent overcrowded with an average population of 1227. There were 611 new prisoners and 1578 separate prisoner movements through reception. The average stay for a prisoner was eight weeks.

## **Section Two: The events of 2 April and the aftermath**

### **(i) The allocation and transfer of the man and the defendant to A wing**

On the morning of 2 April 2004, both the man and the defendant were located on D wing. The man was sharing a cell with a fellow inmate and the defendant was sharing a cell with his fourth cellmate. As noted, D wing is the first night and induction wing. Prisoners are allocated to D wing on first entering Leeds and, after a period of induction, are then moved to one of the other wings as spaces occur.

On D wing on the morning of 2 April one of the duties of the movements officer was to identify prisoners on D wing who were ready to be moved to other wings and match them to the spaces on them. On that morning the movements officer was told there were three spaces on A wing, one in a cell with a prisoner already in it and two in an empty double cell. She said that she was aware that the defendant had put in an application to go to any wing where there were workshops, which A wing had. She said that she went to see the man's former cellmate because he had asked for a move. When she was in the cell the man told her that he too would like to move wings, and she asked him where he would like to go. She said he replied that he would prefer to go to A or F wing. The movements officer said that she wrote the destination cell as A3/02 on the man's cell card and told him to pack his kit. The movements officer said she did not see any interaction between the man and the defendant that morning.

The man's former cellmate said that on 2 April a female officer came to their cell to talk to him about the move he had requested to E wing. He said that the man asked her if he could move to F wing and she asked him whether they would have him back on F wing. He said that the man had replied "I don't know" and then said, "Well what about a space on A wing?" The female officer told him that there were spaces on A wing if he wanted to go there. His former cellmate said that he thought the man had previously spoken to another prisoner, probably a friend, who had encouraged him to go to A wing. The man's former cellmate moved to E wing that morning.

The defendant's former cellmate said that on the morning of 2 April staff came to the cell and told the defendant he was moving to A wing. He said "they just moved me straight on A wing". He said he wasn't given a choice and could not remember whether he was told he would be sharing a cell.

The other prisoner who moved from D wing to A wing on the morning of 2 April. He said that he had been in Leeds prison before and at about 9.30-10.00 on 2

April, he asked the movements officer (whom he described as a woman with long blond hair) if he could move to A wing and she replied that he could. He said he had been on A wing before and thought it was the "best" wing. He said that he packed his kit and went to the wing office where he waited with the man and the defendant to be taken over to A wing. He said that he had never met either of them before.

He said that the man was talking to one of the wing cleaners and the defendant was sitting in a chair by the door of the office. He said he spoke to the defendant but he seemed "not there" and did not really respond to him. He also said that after about ten minutes another female officer came to the office and told all three of them to pick up their kit. He said that the defendant asked where they were going but otherwise there was no conversation between the party until they got to A wing.

The defendant said that the first time he had seen the man was when he went to wait by the wing office at the bottom of D wing. He said that a blond haired female officer moved him over to A wing. He said that the man was "okay" on the way to A wing.

It was the responsibility of the movements officer on duty on D wing on 2<sup>nd</sup> April to collect prisoners from their cells and escort them to their new wings. She remembers escorting the man, the defendant and the other prisoner to A wing. She said that the only conversation during the move took place between her and the man. She said that the man had joked that she would want to move to A wing now that he was leaving D wing. She said they were laughing when they arrived at the office on A wing and that the man had been "his usual cheerful chatty self".

The other prisoner said that when they arrived at A wing office the movements officer Alpha 7, called them in to the office and explained the regime to them. He said there was another officer in the office but he could not remember his name. The other prisoner said that the only conversation in the office was when he had seen the man's name written down and asked him whether it was his name or his location as he couldn't tell. He said that the man had laughed and said it was his name. He said that the defendant still looked "out of it". The other prisoner said that he asked movements officer Alpha 7 if he could go to his cell and he agreed that he could as he knew where he was going. He said he did not see either the man or the defendant again.

The movements officer said that it was approximately 10.30 when the man, the defendant and the other prisoner came into the office. He looked at their respective history sheets and CSRAs and then gave them a brief overview of the rules and expectations of A wing. He said that the other prisoner had been on the wing several times and had been a cleaner there. The defendant was extremely quiet and did not make eye contact. He likened him to "a heroin

addict, just totally not there, just nothing there". He said the man was "quite jovial really". He said he commented to the man that there were several negative entries on his history sheet and He replied that he was coming to A wing for a fresh start, and that he had friends on the wing and that he would not be a problem. The movements officer said he seemed sincere.

The movements officer said that the cell allocation was conducted on D wing so each prisoner knew which cell they were going to before they came over to A wing. He said that at some point while they were in the office the man had asked if he could share a cell with a friend. He said he told him that this would not be possible because his mate had just been moved to share with one of his friends and the move had "taken quite a lot of moving about to get done". He said that the man had reiterated that he would prefer to share with his mate and also at some point had asked to share a cell with another Muslim. The movements officer said he had told him that the wing was full and that he would go in the cell allocated to him. He said that he had told the man that, if he conformed to the regime as he had said he would, then they would look at moving him in the future. He said the man was happy with that and had said "right thanks boss". The movements officer said that all three prisoners then signed their compacts and went up to their cells with their property.

Senior Officer SO Alpha 1 said that he was the SO in charge of D wing on the morning of 2 April. He said he went into the wing office when the man, the defendant and the other prisoner were in there and, out of curiosity, he read their wing files. He said there was "nothing" in the defendant's file but that the man had paperwork resulting from his periods on the 'basic' regime. He said that he had a brief conversation with the man during which he told him that, whatever had happened on previous wings was behind him, and he was on A wing for a fresh start. SO Alpha 1 said that the man had told him he had "no problems" with this.

SO Alpha 1 said that as they were leaving the office the man was the last prisoner out. He said he heard the man ask the movements officer Alpha 7 if he could share a cell with another Muslim prisoner. He said that the officer explained to the man that there was not enough space to do this at present but that it would be possible and there would be a "rotational process". He said that the man was "quite happy" with this explanation.

The officer on duty on A3 landing on the morning of 2 April said that he saw the man's and the defendant coming up the stairs with their cell cards and their bags of property. He thought it was approximately 10.45. He asked for their cell cards and then took them to cell A3/02 and opened the door. The duty officer said that the cell had not been cleaned after the previous occupant had left it that morning and it was quite dirty. He said that the man asked him if he could quickly clean the cell before they took their bags in and he agreed he could. The duty officer

said that he then noticed a wing cleaner on the landing and called him over to sweep the cell out.

The duty officer said his first impression of the two men was that the man was quite friendly to him and the defendant was very quiet. He said that the defendant did not seem interested in cleaning the cell and was leaning on the railings and looking round the wing. The duty officer said that the wing cleaner went to get a dustpan and brush and the man swept the cell out and put the rubbish in a bin. The duty officer said that he remained by the cell while the man was cleaning it. He said the only conversation took place between the man and the wing cleaner. He said they spoke in English and another language that he didn't understand. Once the cell had been swept, the man asked if he could mop it and the Officer gave the wing cleaner permission to get a mop and bucket. The man then mopped the cell.

The duty officer said that he tried to encourage the defendant to speak because he seemed very quiet. He said he told him he could smile if he wanted to at which point the defendant made a half-hearted attempt to smile but did not speak. The duty officer said he left the man and the defendant for a short time to open a cell for another prisoner at the other end of the landing. (The VPs were on 'association' when the man and the defendant arrived at their cell.) He thought that the wing cleaner had gone downstairs at this point. He said he did not know at the time but later found out that a second cleaner, had gone over to talk to the defendant while he was gone.

The duty officer said that as he returned to the cell the the first wing cleaner came up the stairs with a "green scrubber". He said he couldn't remember whether the cell door was open or closed at this point but he let the wing cleaner pass the scrubber into the cell and then closed the door. He said he went back to his duties looking after A3 landing and shortly afterwards VP association finished. He said that VP association usually took place between 10.00 and 11.00.

SO Alpha 1 said that he checked the wing before the prisoners returned from the workshops. He said that VPs return first and he wanted to be sure that normal location prisoners were in their cells. He said he was on A2 landing when he looked up and noticed the man and the first wing cleaner cleaning a cell. He said he saw an A3 landing officer and asked him what was happening. The officer told him that they were just cleaning the cell and then they would be locked up. SO Alpha 1 said prisoners usually return from the workshops at about 11.20.

The first wing cleaner said that he first saw the man when he was on his way over to A wing from D wing. He said that he was standing near the A wing gates waiting to go to the store as part of his duties as a wing cleaner. He said he called out to the man who told him that he was coming over to A wing. He said he thought the man seemed very happy. The first wing cleaner said he knew the

man from the Muslim service on Friday afternoons and had been a close friend of his since late February 2004. He said he did not see the man talking to either the other prisoner or to the defendant as they approached A wing. He said that as soon as the defendant came onto A wing he began to “stare out” the first wing cleaner’s cellmate who was making a phone call.

The first wing cleaner said he stood next to the gate near the wing office while the man and the others went in to have their induction. He said he heard the man ask the movements officer Alpha 7 whether he could share with a Muslim prisoner because he prayed several times a day, rose very early and had previously had problems with non-Muslims who did not like this routine. The wing cleaner said he heard the movements officer Alpha 7 tell the man that he would go “where we fucking put you”. He said that when the man came out of the office he told him that the officers were “fucking about” with him again. He said he told the man to go to the cell he had been allocated and he would try and talk to an officer about getting him a move another day.

The first wing cleaner said he carried one of the man’s property bags up to A3 landing. He said the defendant was very quiet and did not say anything as they went upstairs. He said that cell A3/02 was a complete mess and the duty officer agreed to let them clean it before they went in. He said that he and the man cleaned the cell while the defendant leaned up against the railings. The wing cleaner said he asked the defendant if he was going to help and that He made a gesture as if to say “am I fuck”. He said he warned the defendant that the officers on A wing would not like his attitude but He did not say anything. He said that the man and the defendant did not speak to each other at all. The wing cleaner interpreted this to mean that they did not get on because he said normal procedure would be to introduce yourself to your cellmate.

The first wing cleaner remembered that a second cleaner, spoke to the defendant while he was outside the cell. He said that the defendant did not go into the cell until it was clean. He said that the duty officer was not away for long and when he came back he shut the man and the defendant in the cell. The wing cleaner said that he then remembered that the man had asked for a green pad and a “squirter” and went to get them for him. He then asked the duty officer to open and close the cell door again. He said the last time he saw either the man or the defendant they were both standing in their cell.

The second wing cleaner said he was a cleaner on A wing and one of his tasks was to post the menus through the cell doors. He said on the morning of 2 April he passed cell A3/02 and saw the man, the defendant and the first wing cleaner standing outside. He said the man was talking to the first wing cleaner. As he went past the defendant said “you alright?” He said he did not know the defendant but he obviously knew him. He said he had a brief conversation with the defendant about which wing he had come from and asked him if he was going to share a cell with the man, to which the defendant replied that he was.

The second wing cleaner said that the defendant asked him if there were any empty cells on the wing and he told him there were. He said that, before asking him about the spare cells, the defendant had first looked at the man and at the first wing cleaner to make sure they were still talking. The second wing cleaner said that it was quite common for prisoners who were new to the wing to ask the cleaners about spare cells as the cleaners knew where they were and would know the best officer to approach about a move.

The second wing cleaner said that his first impression of the man was that he was “a bit loud for his own good”. He thought he was “beating himself up” by talking loudly to the first wing cleaner and swearing. He said he did not know what the man and the first wing cleaner were talking about as, although he said they spoke mostly in English, they reverted to “their own language” for parts of the conversation. He said that the defendant did not seem bothered that he was going to share a cell with the man, but observed that he had made an effort to talk to him about finding another cell at the earliest opportunity. The second wing cleaner said that he told the defendant that he would have a look about and talk to him later. He then walked off and did not see the defendant again.

The defendant said that he had thought that the man was “ok” when they were moving from D wing. He said when they got to the cell on A wing “one of his Asian mates” came to the cell, and that was when they started trying to “bully” him into cleaning the cell. He said that the man had changed his attitude. He said he had talked to him before the first wing cleaner arrived and he had thought that the man was “alright”. The defendant said that the first wing cleaner told him to clean the cell toilet and he replied that he would not as it was the cleaner’s job to clean the toilet. The defendant said that after that the man and the first wing cleaner started talking in “Asian” and he thought,

“I know what is going to happen in here, next thing you know I got banged up in my cell and me and him started fighting.”

The defendant said that he and the man started fighting “straightaway” because,

“...he started speaking in Asian and I don’t know, I said why don’t you speak English, why don’t you speak English, why don’t you speak English, talk to me properly and he said he swore at me and he was carrying a knife in there [indicates his waist] and next thing you know we were fighting in the cell and it just all went you know wrestling and that and I got the knife off him and that’s when I tried striking across his face or his neck wherever I cut him and that were it.”

The defendant also said in interview that he had grabbed the man by beads he was wearing, hit him with a chair and kicked him in the face. He was unable to remember how long he had been in the cell before the fight started as he said he was “confused” about this period.

(I would like to emphasise that I am reporting the defendant's account of the events of 2 April and do not make any judgment as to the credence of his version. There is no evidence that the man was in possession of a knife on that day or indeed on any other day he spent in Leeds prison. The evidence is that the man died as a result of an attack that was frenzied and involved extreme violence.)

**(ii) From when the alarm was raised to when death was pronounced**

The security governor, was conducting an adjudication (a prison disciplinary hearing) on a non-compliant prisoner in the segregation unit at the bottom of A1 landing on 2 April 2004. He said he heard a loud screaming, "a sort of shrieking noise", like "an animal in distress". He said he looked at the first senior officer SO and he left the room to find out what was going on. The security governor said that the windows were shut in the adjudication room but the noise could be heard clearly "through the window". He said that the first SO returned to the room and told him that there had been an incident and he thought the adjudication should be adjourned. He said he adjourned the hearing and the non-compliant prisoner was taken back to his cell. He remained in the room to complete his paperwork.

The first SO said that the acoustics were very good in the adjudication room and it was possible to hear "quite a lot that goes on" on the rest of A wing regardless of whether the window was open or not. He said that he heard someone "moaning and screaming" as if they were in pain. His first thought was that it sounded like someone was being raped. He left the room and asked a second SO, who was standing outside the adjudication room, to ask A wing staff to check the cells. He said that he saw that the second SO start walking up the stairs and returned to the adjudication room. He did not hear any further screams.

A first officer said that he was in the adjudication room when he heard screaming coming from one of the landings "upstairs". He said there was also a lot of noise on the wing from the prisoners collecting their lunches. He too thought the screams sounded like someone being raped.

The non-compliant prisoner said he was taken to the adjudication room at approximately 11.00 on the morning of 2 April. He said he remembered there were three staff and the Security Governor in the room with him. He said that after about five minutes he heard a "single loud scream" and he and the staff all looked at each other. He said that the "Senior Officer" asked one of the other officers to find out what was happening on the landings and the officer left the room. He said that shortly afterwards his adjudication was adjourned and he was returned to his cell.

The second SO said she was walking past the adjudication room on her way to the main office when the first SO asked her to investigate noise “upstairs” that sounded like somebody “being beaten or raped”. She said she went up the stairs and saw about five officers standing on A2 landing by the stairs. She said they were almost directly underneath cell A3/02. She told the movements officer Alpha 7, that the adjudications had been interrupted by what sounded like someone being beaten or raped. She said that the movements officer said that it must be coming from A3 landing and that he and the first officer went to investigate.

The second SO said that she did not hear any of the noises described by the first SO, either on S1 landing by the adjudication room or A2 landing where she spoke to the movements officer Alpha 7. She said that she could see that the VPs on A4 were coming down to A2 to collect their lunches and there was a lot of noise from prisoners “clattering” trays and talking. She said that prisoners on the segregation unit were about to be given their lunch and this involved the cleaners going up to A2 in the lift to collect the meals for them. Taking this into consideration, she thought the first SO must have asked her to speak to A wing staff at about 11.40. She said that, apart from the noises heard in the adjudication room, there was no disruption and no sign that anyone was aware of anything being wrong.

The movements officer Alpha 7 said that he was on A2 landing during prisoners’ lunchtime. He said that the prisoners had been collecting their lunches for maybe five or ten minutes when the second SO came out of the segregation unit. He said the segregation unit steps led to exactly where he was standing. He said that the second SO told him that screams had been heard and that it sounded like someone was being raped. He said that he asked her where the noise was coming from and she told him that it was from somewhere above the adjudication room. He thought the time was approximately 11.50. The movements officer said he immediately went up to A3 landing followed by the first officer. He said he saw another officer, the second officer on A3 landing and told him that he thought something was happening in the A3 cells, probably a fight. He said he went along the cells looking through the observation panels. As he neared A3/02 he said he heard two loud bangs, “like wood being hit onto the floor”, coming from the end of the wing. He said he went to cell A3/02 and saw the man on the floor of the cell with the defendant standing over him looking at him. He said he could see nothing in the defendant’s hands.

The movements officer Alpha 7 said he realised that for someone as powerful as the man to be on the floor a violent act must have occurred and shouted to the SO Alpha 1 to lock the wing. He then opened the cell door and told the defendant to leave the cell. He said that the defendant walked straight out of the cell and at this point he noticed blood on the cell floor. The movements officer Alpha 7 said he asked the second SO to take the defendant’s straight to the segregation unit and get his clothing “bagged and tagged”. He then entered the

cell and saw that the man was badly injured. He stepped back on to the landing so he could use his radio to call for medical assistance.

The movements officer Alpha 7 said another officer passed him some rubber gloves and he went back into the cell. At this point he saw a serious injury to the front of the man's throat and placed a towel over the injury. He turned the man more into the recovery position" and saw another large laceration across the back of his head. He said the first officer passed him another towel and he placed this onto the second injury. The movements officer said that the man had a pulse and he tried to speak to him to calm him down. He said the man tried to move and stand up and he had to pin him on the floor. He said he tried to reassure the man that help was on its way and tell him to lie still as he had hold of his wounds. He said that the first officer helped to control the man's legs. He said that the man did not try to speak but he thought he could hear him. After a while, when the man seemed to be getting "quite low", he asked him to blink if he could hear him and the man tried to blink.

The movements officer Alpha 7 said that the man was lying two or three feet from the cell door with his head facing the door. He said his jeans were "pulled down around his thighs" revealing his boxer shorts. He noticed that a packet of cereal and some milk had been spilled on the floor and that there were two large property bags in the cell with their tops open. He thought these belonged to the man

The movements officer Alpha 7 said he remained with the man for maybe 10 or 15 minutes while nursing staff tried to give him oxygen. He said that he noticed Healthcare Officer HCO in the cell doorway and asked him to take over as he was physically drained. He said he left the cell and the HCO took over applying pressure to the man's wounds.

The first officer said he was on A2 landing at about 11.50 when the second SO came up from the segregation unit. He said she told him that an adjudication had been stopped and asked if the wing officers could investigate a noise. He said that he and the movements Officer Alpha 7 went up to A3 landing where they met the second officer. He said the movements officer Alpha 7 opened the flap to A3/02 and called for medical assistance. He saw the movements officer open the cell door and tell someone to leave the cell. A prisoner, whom he now knew to be the defendant, walked out of the cell and the Second officer asked him if he had any weapons. He said he saw the defendant hold out his hands in front of him. He heard the defendant say something to the second officer but could not distinguish the words. The Second officer then escorted the defendant to the segregation unit. The first officer said the defendant looked "calm" and "very passive".

The first officer said that he and the movements officer Alpha 7 waited for some latex gloves to be brought from A2 landing and then went into cell A3/02. He

said this took a matter of seconds as the gloves were passed through the netting between A2 and A3 landings. He said the movements officer got a towel and applied pressure to the wound on the man's throat. The first officer said the man tried to get up and he helped the movements officer keep him on the floor by keeping his knees in the recovery position. The first officer could not remember there being a towel at the back of the man's head. He said he did notice that, although the man's head was towards the cell door, there was a significant amount of blood under the bed at the opposite end of the cell. He said he could see the man's s beads under the bed. The first officer said that the man was wearing tracksuit bottoms and they were round his ankles. He was also wearing boxer shorts but these were in place.

The first officer said that two nurses next entered the cell and one of them dressed the man's ear, which was badly cut. He thought the nurses, with the movements Officer help, then gave oxygen to the man but said it was difficult for him to see as he was down by the man's feet. The first officer thought that he was in the cell for maybe 10 or 15 minutes. He said he thought the medical staff arrived within one or two minutes of the radio call. He said a doctor appeared in the cell doorway but did not enter the cell. He said that he knew the man was still alive when the oxygen mask was put on because he could see his breath as he breathed out. The first officer said he and the movements officer left the cell when the paramedics arrived.

The second officer said that he was standing on A3 landing at approximately 11.50 assisting with the flow of prisoners collecting their lunches when the movements officer and the first officer approached him and told him that there was "a commotion" or "a fight" somewhere on the first quarter of A3. He said he was "surprised", as he had not heard anything. He said that he had been standing at the top of the stairs on A3 landing for about 15-20 minutes and had not heard anything untoward at all. He confirmed that the VPs were coming down from A4 to collect their lunches. This meant that the first quarter of A3 landing that contained prisoners on 'normal location' was still locked up. The second officer agreed that there would have been noise from cell doors being opened and closed but said that the noise levels on the wing were not out of the ordinary.

The second officer said that the movements officer Alpha 7 asked him to "give him a hand" and he followed the movements officer and the first officer down the wing. They each checked the cell observation flaps. He said that the movements officer looked into A3/02, opened the door and asked someone to leave the cell. He said the defendant came out of the cell and walked towards him. He said the defendant was "compliant" and he asked him whether he had any weapons. The second officer said he was about to search the defendant when he noticed that his right hand was covered in blood. He did not have any surgical gloves with him and so did not perform the search. He said that he did not see any blood anywhere else on the defendant's.

The second officer said he ordered the defendant to go directly to the segregation unit. He said that the defendant said to him, "I'm not a racist, I took the blade from him". He said that as He approached the stairs he made another unsolicited comment, which was "he attacked me". The second officer said that this was all that the defendant said to him on the way to the segregation unit. He said that the defendant appeared "very calm".

The second officer said he left the defendant in the segregation unit and ran back up to A3/02 to see if he could be of assistance. He saw the movements officer trying to stem the flow of blood from the man's throat. He said by this time nursing staff were in the cell and the SO Alpha 1 was in charge outside the cell. He said that the Deputy Head of Residence asked him to search outside the cell for a weapon. He left the wing and searched outside but could not find a weapon. He returned to the wing, told the Governor that he had not found anything and, as there was nothing else he could do to help, went to the wing office to write his report.

Nurse Hotel 3 said she was carrying the radio with call sign Hotel 3. This means that she was designated to respond first to an emergency call. She said she was in A wing treatment room when she received a call to go to cell A3/02 urgently for a "red call". Nurse Hotel 3 said that a red call indicated that there was bleeding and the fact that the call was urgent indicated to her that it was "a big bleed". She said she grabbed a "slash pack", which has gauze swabs and saline solution, locked the treatment room and went straight to A3/02. Before she got to the stairs she saw the defendant on A2 about to go down the steps to the segregation unit.

Nurse Hotel 3 said that, when she arrived at the cell, she saw one officer kneeling by the man's chest and another at the back of the cell. She said she could see a lot of blood at the bottom of the cell. The man had his head near the cell door and was bleeding heavily. The nurse said that she realised how serious the situation was and, before entering the cell, she asked control to call for Hotel 4 and an ambulance. She was told that Nurse Hotel 4, was already on her way. She then entered the cell.

She said that the movements officer Alpha 7 was applying pressure to try to stop the bleeding. She said that the man kept trying to get up which made applying constant pressure difficult. She said both she and the officers talked to the man and tried to keep him calm and reassure him. She said the man appeared to be aware of what they were saying because he looked at them when they were speaking and he did calm down. She said she tried to find a pulse. The movements officer was happy to continue applying pressure to the wound, which, she said, was good as he was doing an "excellent" job. She then asked somebody to get the emergency equipment, a doctor and more healthcare cover.

She said that the duty doctor arrived within a couple of minutes and inserted a cannula [a narrow tube for removing fluid from bodily cavities] into the man's.

Nurse Hotel 3 said that the HCO arrived at about the same time as the doctor and he took over putting pressure on the man's wound as the movements officer was tired. She said she managed to get a pulse reading on the man's after giving him oxygen and he was breathing. Nurse Hotel 3 said that the man was wearing prison issue jeans, which were around his ankles. She said he had socks on his feet and she thought his trainers were by the cell door. She thought that paramedics arrived after she had been in the cell for about five or ten minutes. She said that she had called the control room after the event and had been told that she received the emergency call at 11.49.

Nurse Hotel 3 said that, as the man was breathing, the main task for staff was to stop the bleeding. She said that all of the equipment available to them was adequate apart from the suction machine, which was "a bit dated". She said that the ambulance paramedics took over when they arrived and she went to the ambulance with one of them to collect a backboard and some more equipment. When she returned to the wing she waited outside the cell as the paramedics were giving the man cardiac massage. She said she thought this was to get his blood to pump more quickly rather than because his heart had stopped. She said that the man was then taken to hospital by ambulance.

Nurse Hotel 4 said that, on the morning of 2 April 2004, she was working on D wing treatments. She said she held the radio with call sign Hotel 4, which meant that she carried the back up radio for calls for medical assistance. She said she heard the call for Hotel 3 to go to A wing and thought that it sounded like a "serious event". She said she immediately picked up a 'slash pack' and made her way to A3 landing. As she arrived on A3 landing she received a call from Hotel 3 asking for assistance. She said that she called the control room later and was told that Hotel 3 was called at 11.49 and Hotel 4 was called at 11.50.

Nurse Hotel 4 said that when she entered cell A3/02 she could see the man laid in the recovery position and the movements officer Alpha 7 holding a towel around his neck. She said that the movements officer was reassuring the man and the bleeding seemed to be under control. However, because there was a large amount of blood in the cell she put out a call for a doctor and more help. This call was made at 11.52. She said that the blue light ambulance had already been requested by the time she arrived at the cell. There was another officer in the cell but she did not know his name.

Nurse Hotel 4 said she got on her hands and knees with the movements officer and tried to reassure the man. She said he was fighting to get up but did not speak at all. The oxygen arrived and the man was given "oxygen at 10 litres". She said they tried to assess his pulse and oxygen levels using the "stats machine" but could not get a result. Two more healthcare officers, the

Healthcare Principal Officer HCPO and the Healthcare Senior Officer HCSO, arrived together with the duty doctor. The doctor 'cannulated' the man, gave him more fluid and tried to check his pulse. The healthcare officers removed the furniture from the cell to give them more room to work. She said the paramedics arrived and took over. She said they moved the man into a position where he could be given cardiac massage and intubated him to make sure he was breathing properly. They then "boarded" him and he was taken to hospital.

Nurse Hotel 4 said that the emergency equipment was brought to them as quickly as possible. She said that the only piece of equipment she had any concerns about was the suction unit, which was "difficult to work". She said that the man was wearing jeans, which were around his ankles, and he was wearing boxer shorts. She said that she thought that the movements officer had been "absolutely outstanding". She said that when she arrived he had the situation under control and was reassuring the man.

The doctor said that, on the morning of 2 April 2004, the HCPO came to his office and told him that there had been a serious assault on A wing and he was needed. He said he could not be sure of the time but thought it was around 11.20. He said he immediately went to A wing. When he entered the cell he saw the man lying on the floor in the recovery position being attended by two prison officers and two nurses. He said the man was breathing but not moving. The doctor said he was told that the man had a "cut throat" and that paramedics were on the way. He said he tried to feel for a femoral pulse (the pulse at the top of the leg) but could not find one.

The doctor said paramedics arrived at the cell at about 12.00 and immediately tended to the man. He said he gave him fluid and started to feel the femoral pulse. The cardiac monitor showed that the man's heartbeat was "40 per minute regular". He said one of the paramedics was inserting an endotracheal tube to make his breathing easier and he was asked to check that it was in the correct place. This he did and confirmed that he could hear the man breathing. The doctor said that about 12.25 he noticed that the man had stopped breathing spontaneously and the cardiac monitor was showing a flat line. He said the paramedics started cardio pulmonary resuscitation (CPR) and after about five minutes they decided to take him away. He said that the man's condition at this point was "very poor" and "in all practical purposes I felt that he was probably not alive". The doctor said that after the paramedics had left with the man he went back to his office and wrote up his notes. He said he had written on his notes that the time was 12.32. He said he was satisfied with the first aid given to the man.

The HCO said that he was in the Healthcare Centre on 2 April 2004 when another officer told him that he was needed on A wing. He said he walked to the centre (the central area from which access is gained to A, B, C and D wings), which was about 250 yards away, because that was where the emergency

equipment was kept. He said he saw a nurse opening the emergency equipment cupboard. She told him that nurse Hotel 3 and nurse Hotel 4 were already on A wing and he said that he noticed that they had already taken the 'ambu bag'. He explained that the 'ambu bag' contained oxygen and resuscitation equipment. He said that he assumed he was attending a 'blue call', which meant that the person is not breathing, so he took the defibrillator from the cupboard and made his way to A wing.

The HCO said he was directed to A3/02 by staff. In the cell he saw two nurses, two officers and the man lying on the floor. He said one of the officers was holding a towel to the back of the man's head and one to his throat. He said that the officers were talking to the man, trying to calm him down. He said that the man was lying in the recovery position with his head towards the door. He said that he helped put the oxygen mask over his mouth. He saw a deep cut, maybe four inches long, to the back of the man's head. He said he realised that the man had lost a lot of blood and that he needed to be cannulated to get more fluid into him. He said he asked the HCPO to get the fluid kit from the centre and meanwhile checked the man's airways. He said that the man kept trying to get up and he told him to lie still so that he could help him. He then took over from the movements officer Alpha 7 and held the towel to the man's throat.

The HCO remembered that one of the officers had told him that man's jaw was very loose. He said that he felt it slightly and thought that it might be fractured. He said that he heard on the radio that the ambulance had arrived and felt relieved. He said that the doctor then arrived and tried to feel for a femoral pulse. The HCO said that at this point he noticed that the man's jeans were around his ankles. The doctor asked him to confirm that there was a femoral pulse, which he did. He said that the man was obviously in a state known as 'bretocardio', which means that his pulse was starting to slow. He said that the HCPO returned to the cell with the fluid kit and the doctor cannulated the man.

The HCO said the ambulance crew then arrived at the cell. He said they were not paramedics but Emergency Medical Technicians (EMTs), which surprised him as he had expected at least one paramedic. He said he remembered the HCPO asking them if a paramedic supervisor was coming and being told that a paramedic team was seconds behind. The HCO said that the paramedics did arrive very quickly after the EMTs. He said that nurse Hotel 4 continued to give him fluids, although he said that ideally the man should have been given blood.

The HCO said that one of the EMTs went to get their own defibrillator because it had a screen attached and they would be able to see the man's heartbeat. The EMTs cut the man's sweatshirt off and put the defibrillator on his chest. The machine showed that he had a heartbeat but that he was in 'Electrical Mechanical Disassociation' (EMD). This meant that his heart was beating but that nothing was happening. This was probably due to the loss of blood. One of the EMTs began chest compressions. The paramedics arrived and the EMTs

handed over to them. It was decided that one of the paramedics would intubate the man and he was laid flat on the floor. The HCO said he took off the man's jeans because they were making it difficult to move him.

The HCO said that the man went into cardiac arrest. He was given oxygen and fluid and the paramedics and nurses continued CPR until the stretcher arrived in the cell. He was put on the stretcher and CPR was stopped. He said, at this point, he realised that the man was not going to live. He followed the stretcher to the ambulance and then went back to the treatment room on A wing.

The HCPO said that he was in the Healthcare Centre talking to the HCSO when he heard the radio call for Hotel 3. He was holding the radio with call sign Hotel 9, the unit manager's radio. He said when he heard Hotel 3 call for Hotel 4 and general medical assistance he called a colleague to ask the HCO to go to A wing. This was because the HCO was a trained EMT and had most expertise in dealing with emergency situations. He said he and the HCSO then made their way to A wing. On the way he heard the call for the doctor and stopped in the Doctor's office to tell him he was needed on A wing.

On arrival at A wing the HCPO said he did not go into the cell but he could see nurse Hotel 3, nurse Hotel 4, the HCO and two officers in there with the man. He said that the doctor arrived within minutes and went into the cell. He said that the HCO asked him to bring another oxygen cylinder and the intravenous infusion kit and he went to get these from the emergency treatment area on the centre. He passed them into the cell and then moved further down the corridor with the HCSOs as the paramedics arrived.

The HCSO said that he was talking to the HCPO when he heard the calls on the radio for Hotel 3 and Hotel 4. He said that the second call alerted him to the fact that the incident was serious and he and the HCPO decided to go to A wing to see if they could help. He said the HCPO went to tell the duty doctor that he was needed on A wing and then they walked over together. He said that he could see through the cell doorway that the movements officer Alpha 7 was trying to stem the flow of blood from the man's neck. He said that he could see the man lying with his head towards the bed and his feet slightly under the bunk beds. He noticed that he did not appear to be wearing trousers. The HCSO said that he passed medical equipment into the cell and also removed the cell television, locker and chair to give the medical team more access.

The HCSO said that he heard on the radio that two ambulances had arrived and four ambulance staff arrived simultaneously on the wing. He thought that they arrived at about 12.05. He said that after about five minutes the ambulance crew decided that the man needed to be taken to Accident and Emergency at Leeds General Infirmary (LGI). He said they discussed this with the duty doctor, who agreed that nothing further could be done in the prison.

The SO Alpha 1 said that, on the morning of 2 April 2004 at about 11.50, he was standing on A2 landing supervising the VPs collecting their lunches when the movements officer Alpha 7 shouted to him from A3 landing that there had been an incident. He said he went up to A3 and saw the movements officer, the first officer and the second officer standing outside one of the cells. He then saw the defendant walk out of the cell with his hands covered in blood. The second officer escorted him to the segregation unit and that was the last he saw of the defendant.

The SO Alpha 1 said he looked into cell A3/02 and saw the man on the floor clutching his neck. He said there was blood, milk and other debris on the floor and his first impression was that there had been a fight. He said he called for Hotel 3 on his radio and then called down to the other wing SO on A2 landing and told him to start locking the prisoners away and not to unlock anyone else for lunch. He said that the movements officer Alpha 7 and the first officer were given gloves and went into the cell. The movements officer persuaded the man to remove his hands from his throat so that he could apply pressure to the wound with a towel.

The SO Alpha 1 said that nurse Hotel 3 arrived within seconds of the call for Hotel 3 as she was in the treatment room downstairs. He said she immediately asked for help and he used his radio to put a 'red' call for Hotel 4, the doctor, any available Hotel staff, Oscar 1 (call sign for the orderly officer who is nominated to manage incidents), the duty governor, security and the police liaison officer. He said that at this point the control room had switched the radio to 'talkthrough', which enabled him to speak to anyone holding a handset. He said he also asked for an ambulance. He said that nurse Hotel 4, healthcare staff and the duty doctor were very quickly on the scene. He said that the Duty governor and Oscar 1, the PO from Security, were also very quick to respond. The security SO responded from Security and the wing governor, deputy head of residence, was also present. He said he briefed everyone as they arrived.

The PO from Security, said that he was orderly officer (Oscar 1) on 2 April. He said he was in the security office when he heard a call on the radio from the SO Alpha 1 that there had been a serious assault on A wing. He said he told his two senior officers to go straight to the wing. He stopped off at the police liaison officer's room and asked the Detective Constable Police Liaison Officer to accompany him to A wing. When he arrived at A wing, The PO Oscar 1 said he could see that the man was receiving medical attention and so he took on the role of liaising with control and ensuring a clear passage for the ambulance and paramedics. He said he told the first Security SO to go to A2 landing, organise the escort equipment and make sure access was clear. He told the second Security SO to start a log of all the people who entered the wing. PO Oscar 1 said that he instructed the control room to leave the vehicle gates open to ensure that the ambulance could leave as quickly as possible. He escorted the

paramedics and the man to the ambulance and watched it leave with two escorting officers on board.

The second security officer said he responded to the call that there had been a serious assault on A wing. He took his camera and some tape to seal off the landing if required. He said that he looked briefly into cell A3/02 and could see that the incident was very serious. He said he opened a log at approximately 11.55 to record who entered the landing and the cell and made sure that only staff who were required were allowed into the area. He said that the primary duty of security staff was to preserve evidence and keep the area as sterile as possible. He remembered that the man's trousers were partially down and that they were later removed in order to help them move him. He said that, once the man had been taken to the ambulance, he sealed the cell, taped off the end of the wing and sealed the areas used to transport the man to the ambulance. He said it was roughly 12.30 by the time he had sealed the area. He thought that the paramedics arrived at approximately 12.05 or 12.10.

The duty governor on 2 April said he heard three calls over the radio, increasing in urgency, from about 11.50. After the third call he decided to go to A wing and arrived there at approximately 12.00. He said he was briefed by the SO Alpha 1 outside cell A3/02 but did not go into the cell. At about 12.10, he said, the first ambulance crew arrived and he collected them and brought them to the cell. He said the second ambulance crew arrived shortly afterwards but he couldn't remember who brought them to the wing.

The first accompanying officer said that the accompanying SO told him to accompany the man in the ambulance to the hospital together with a second accompanying officer. He said he travelled in the front of the ambulance, which arrived at Leeds General Infirmary (LGI) at approximately 12.50. He said that ambulance staff put the man in the resuscitation room and he and the second accompanying Officer waited outside. He said that a "few minutes" later a doctor told him that the man had died. The Prisoner Escort Record (PER) form completed by the first accompanying officer shows that the ambulance left Leeds prison at 12.40 and arrived at LGI at 12.45. He recorded on the PER that he was told at 13.00 that the man had died and that he phoned the control room to report the death at 13.05.

There is only one cell adjacent to cell A3/02. The first prisoner said he was in cell A3/03 on 2 April. He said he and his cellmate went to the gym at about 8.00 and returned at about 9.00. He said that, at about 11.30, he heard officers shouting outside on the landing and someone calling for an ambulance. Some time later, he thought about 12.00, he said he was let out to collect his lunch and returned to his cell. At about 3.30 a notice about the man's death was put under his door. The first prisoner said he had not heard any noise from the cell next door until he heard the officers outside.

The second prisoner said that he returned from the gym at about 9.00. He said he went to collect some hot water at about 10.30 and then put his music on loud and started to "work out" in his cell. He said he heard no noises from cell A3/02 and was not even aware that the cell was occupied. At approximately 11.30 – 11.45 he said he noticed several officers outside his door but it was only later that he became aware that someone had died in the cell next door.

(iii) What happened to the defendant

The second officer took the defendant to the segregation unit (S1) from A3/02. He said he took him to the "sterile cell" and told colleagues that there had been a serious incident and the defendant's clothing would require "bagging and tagging" (being sealed as evidence). He then returned to A3 landing.

The second SO said she was supervising lunch on S1 when the second officer brought the defendant down the stairs. The second SO said she went into the cell with him and saw that the defendant appeared "dishevelled" with "glistening" skin and "red raw" hands. She said his face appeared "totally blank". She then left the cell while the defendant was strip searched by male officers. She collected some evidence bags from the PO's office and left them outside the cell door.

The first Incident officer said he took the defendant to cell S1/33 where he and the second incident officer instructed the defendant to remove his clothes. He placed the defendant's clothing in nine separate evidence bags. The first incident officer said he did not realise the severity of the incident because the defendant appeared like "a normal prisoner, not so much shocked as withdrawn". He said the defendant complied with everything he asked him to do. He said he spoke to the defendant only to ask about his trainers, which were new.

The second Incident officer said that the defendant had not spoken during the strip search. He said he had blood on his hands but he did not notice any injury on the defendant. He said that the defendant was taken to the "special" cell S1/33. This is a cell with nothing but a plinth with a mattress on it at one end and a toilet.

The deputy head of residence said that, as he was the governor in charge of the segregation unit, it was his job to see every prisoner located there. He said he and the Disciplinary Hearing SO went to see the defendant who told him, "he was making racist remarks to me, he pulled out a knife and we fought for it. I got the knife off him and did him". The governor said he told the defendant not to say anything else to him. He said he had simply wanted to know if the defendant was alright and he was concerned not to prejudice police enquiries. The governor said that the defendant was very calm and seemed "totally unconcerned" by what had happened.

The Governor said he left the cell and went to speak to the Detective Constable Police Liaison Officer and to the Police Liaison Officer. As a result of their conversation he asked staff in the segregation unit to watch the defendant and stop him washing himself or getting rid of evidence in any other way. The defendant was not allowed a drink or a meal either.

The SO conducting the disciplinary hearing said that the deputy head of residence told staff to keep watch on the defendant until the police arrived. He said staff kept watch in twos and sat on chairs in the cell with the defendant. He shared a watch with the SO Colbeck and with the First Watch Officer. He said the defendant yawned when he spoke to him. He asked the defendant if he was tired and He replied that he was "bored". They had a short conversation about the defendant's sentence.

The first watch officer remembered the defendant talking to the disciplinary hearing SO. He said he remembered the defendant saying he was bored. The first watch officer said that the first and the second incident officers relieved him and the SO.

The second incident officer said that he was taking his turn watching the defendant when the police arrived to arrest him. He heard them charge him with murder and he accompanied them to the police car. He said that the defendant did not speak at all during this time.

The defendant was taken to Pudsey Police station at 14.33. He was subsequently charged with the murder of his cellmate. He remained in police custody until 5 April when he was transferred to HMP Wakefield. In July 2004 he was convicted of murdering his cellmate and sentenced to life imprisonment.

#### (iv) Timings

D wing movements book shows that the man moved from cell D4/07 to cell A3/02 and that the defendant moved from cell D4/26 to cell A3/02. There is no time recorded against the entry. The movements officer on D wing confirmed at interview that she made the entries in the D wing movements book. A wing movements book records that the man, the defendant and another prisoner arrived on A wing at 10.30. The kitchen records show that the lunchtime meal was ready to be delivered at 11.30. The Kitchen Principal Officer is the PO with day to day responsibility for the kitchen. He was not on duty on 2 April but estimated that it takes between five and ten minutes for the food to be transported to the wings via trolleys. The F256 Record of Hearing and Adjudication for charge number 679-04 brought against the non-compliant prisoner on 2 April shows that the adjudication was opened at 11.40 in front of the security governor. Part three, the Record of Hearing, states "opened and adjourned, serious incident in prison".

The exact timing of events between 10.30 and 11.49, when the control room log records the call for Hotel 3, is uncertain. The following approximations have been pieced together from the relevant interview transcripts. The first wing cleaner estimated that the man and the defendant arrived at their cell 15 minutes after arriving on A wing. The second wing cleaner who also saw them arrive on the wing, puts them outside the cell after ten or 15 minutes. The Duty Officer recalled that he first saw the man and the defendant at about 10.45.

The SO Alpha 1 said that the association period for VPs is usually between 10.30 and 11.15. VPs who attend the workshops usually return to the wing at 11.20. The duty officer and the SO Alpha 1 both recalled that the VPs were on association when the man and the defendant were outside their cell. The SO Alpha 1 recalled that he saw the man and the first wing cleaner cleaning the cell about half an hour after he had first seen the man in A wing movements office. He said he was checking the wing to make sure prisoners on normal location were in their cells before the VPs returned from the workshops. The first wing cleaner remembered the SO Alpha 1 looking up at them from A2 landing shortly before the door to cell A3/02 was closed. This evidence suggests that the man and the defendant were shut in their cell at approximately 11.15.

The disciplinary hearing SO thought that he asked the second SO to speak to A wing officers about the screams heard in the adjudication room at “five or ten to 12.00”. The second SO said that the food was ready to serve and the cleaners had gone to collect it from A2 (on S1 the lunchtime meal is taken to each cell by the wing cleaners). She said the cleaners normally collect the meals at about 11.45. When she spoke to staff on A2 landing she noticed that A wing prisoners were collecting their food. When she returned to S1 she said that the cleaners were serving the food, which led her to estimate the time at 11.50 at the latest. The movements officer Alpha 7 remembered that the prisoners had been collecting their lunches for five or ten minutes before the second SO came up to the landing. The second officer estimated that it takes between eight and ten minutes to provide food to each section of A wing. He thought that nearly all the VPs had collected their meals when the second SO appeared. If the lunchtime meal was ready to leave the kitchen at 11.30 and took a maximum of ten minutes to arrive on the wing then these timings would be consistent with the alarm being raised on the segregation unit shortly after 11.45. This would mean that the man and the defendant were in cell A3/02 together for approximately 30 minutes before the alarm was raised on the segregation unit. (This fact means that the defendant’s account – cited earlier – that he and the man had started fighting “straightaway” is most implausible.)

The control room log was opened at 11.49 when Alpha 7 called to report a serious assault on a prisoner and requested Hotel 3 be called. The log shows that nurse Hotel 3 arrived at the scene at 11.50 and called the control room to log her response. Also at 11.50, Alpha 1 requested further assistance from Hotel 4 and Health Care and asked for a blue light ambulance.

At 11.51 the radio net was put on 'talkthrough' allowing anyone carrying a handset to talk to each other. Also at 11.51 the doctor was requested and an ambulance called. At 11.58 the first ambulance arrived at the prison and at 12.07 the second ambulance arrived. The log records both ambulances left the prison at 12.40. The post mortem report records the man's time of death as 12.58. At 13.05 one of the escorting officers, the first accompanying officer, called control to tell them that the man had been declared dead.

The security SO kept a log of who entered and left cell A3/02. When he arrived on A3, nurses Hotel 3 and Hotel 4 and the HCO had already arrived. In his incident report [doc 12] he gives the following timings:

“11.55 Hospital PO and SO entered cell to assist  
12.00 Duty doctor entered cell  
12.05 Movements officer Alpha 7 and first officer left cell  
12.10 Paramedics arrived, first two paramedics, followed at  
12.15 by two more paramedics  
12.15 Hospital staff, PO and SO left sterile area  
12.20 Nurse Hotel 3 and one paramedic left cell for a stretcher,  
returning a short time later with the equipment  
12.30 All personnel left the cell with the inmate to the ambulance.”

#### **(v) The prison's immediate response to the murder**

The action checklist completed by staff on 2 April shows that the inner part of A3 landing was isolated at 11.50. From this time onwards only persons who needed to enter the area were allowed to do so. Cell A3/02 was sealed at 12.30. The whole of A wing was sealed at 13.00 and the incident log officer kept an incident log, which recorded who entered the wing and at what time, until 18.50. Scene of crime officers were on the wing between 15.02 and 15.10. They attended cell A3/02 again at 15.52. It is not recorded when they left the wing, but presumably this happened after the log was closed at 18.50.

The action checklist shows that the post-incident care team officer of the post-incident care team was informed of the attack on the man at 12.30. The Area Manager was told of the death of the man at 13.15. The Chaplain was told at 13.30, Safer Custody Group were informed at 14.00, the Independent Monitoring Board were told at 14.10, National Operations Unit were told at 14.15 and the Governor was told at 14.25.

The duty governor, said that, after the man was taken to hospital, he had a brief conversation on the Centre with the PO Oscar 1. As a result of that conversation he decided that the death in custody contingency plans should be activated even though the man had not yet been pronounced dead. He went to the Governor's office and saw that the head of the central business unit had already got the

contingency plans out. The duty governor said the head of the central business unit began going through the action checklist and assigning tasks to managers as they arrived in the office. He said he began to collate paperwork relating to the man and to the defendant. He remembered leaving the office to get the security files from the security office. The duty governor said he recognised the defendant's name and prison number from a Security Information Report (SIR) that had been partly processed. (This is discussed in more detail in Section 3 (vii) below.)

The duty governor said he attended the hot debrief shortly after 13.00. He remembered receiving a call from control room staff telling him the man had died. He could not remember whether this was before or after the hot debrief. The duty governor said the hot debrief lasted for about 15 or 20 minutes. Afterwards he returned to the Governor's office and continued to work through the paperwork. He could not remember when the decision to try to contact the man's family was taken. He said that this was normally done by a member of the Chaplaincy team. He did remember that he was listed as the liaison for the family on the action checklist.

The head of residence, said that he went directly to the Governor's office when he heard there had been a serious incident. He said there were already several managers in the office. He said he left to lead the hot debrief, which he thought took place at about 14.00. Afterwards he returned to the Governor's office. He remembered the Deputy Governor, the head of the central business unit, the duty governor, the new race relations officer, the head of regimes learning and skills and, later, the Muslim chaplain, all being present. He said that, in practice, he, the head of the central business unit and the duty governor managed the incident. He said tasks from the action checklist were allocated around the different managers and not completed in strict numerical order. He said he was not involved in the initial attempts to contact the man's next of kin but remembered being told that the family could not be contacted by phone. The head of residence said that he authorised the Muslim chaplain and the head of regimes learning and skills to drive to the family home.

The head of the central business unit said that he made his way to the Governor's office as soon as he was made aware that a serious incident had occurred. He could not recall the exact time he got there but said that the head of residence, new regimes learning and skills and duty governor were already there. He said that the death in custody contingency plan was activated as soon as the prison were notified that the man had died. He confirmed that most of the entries on the action check list were in his handwriting and that the entries timed prior to 13.05 (when the log records that the prison were informed of the man's death) were taken retrospectively from the control room log. He has confirmed that his first timed entry on the checklist was 13.50. He said that he remembered the Muslim chaplain trying without success to contact the man's family by phone. He said that he and the Muslim chaplain were named on the action checklist as

contacts for the next of kin. The head of the central business unit said that the managers who were mainly responsible for managing the incident were himself, the head of residence and, initially, the duty governor.

The Deputy Governor contacted my investigators following receipt of my draft report. The Deputy Governor was not interviewed during the course of the investigation as it had been believed that he was peripheral to events. The Deputy Governor said that, in fact, he was present in the Governor's office at the time of the man's murder and that he remained there to co-ordinate the prison's immediate response.

Members of the post-incident care team were on A wing from 12.30 and available to staff. A hot debrief led by the head of residence took place in the multi-faith centre some time after 13.00. The hot debrief was co-ordinated by PO Oscar 1. PO Oscar 1 noted, in a memo to the Governor of 5 April, that the purpose of the hot debrief had been threefold: to provide an overview of the incident, to make staff aware that the care team and chaplaincy team were available to them immediately and in the future, and to thank staff for their support and actions taken during the incident. He said that, after consultation with the police, staff had not been given the opportunity to discuss the incident in detail. Those present included nurses Hotel 3 and Hotel 4, the HCO, The HCPO, HCSO and two members of the staff care team. The healthcare and nursing staff held a clinical debrief in the Healthcare Centre prior to the hot debrief.

On the advice of the police, Senior Officer Alpha 1 and the Movements Officer Alpha 7, the first and the second officer and were kept separately from other staff. They had their uniforms removed as evidence and were interviewed by the police at about 15.30. The head of residence debriefed them separately in A wing movements office. The Post-incident Care Team Officer also visited them and stayed while the police interviewed them.

Most of the staff directly involved in the events of 2 April were off duty on 3 April, a Saturday, and report that members of the care team phoned them at home to see if they were alright.

At 12.45 staff were called from D wing to perform a controlled unlock of prisoners on A wing so that the remainder of the lunches could be served. The incident log officer said the deputy head of residence and other staff visited prisoners on A wing who were due for domestic visits. They explained that there had been a serious incident and that staff would contact their families to explain why the visits could not go ahead at the usual time. All visits were re-arranged for later that afternoon. The man's friend on A wing, said that "a governor" came to his cell to tell his cellmate that his special visit had been cancelled and about ten or fifteen minutes later a notice was put under the door about the death of the man.

The Imam, said he and the Muslim chaplain, began visiting the Muslim prisoners just before 14.00 to tell them that Friday prayers were cancelled. He went to every wing except A wing, which was cordoned off. He said the prisoners asked him why prayers were cancelled and he told them there had been an incident. He said some of the prisoners knew that the incident involved the man and asked about him.

There was a concern that prisoners seen at risk of self-harm would be especially upset and officers from the care team remained on A wing during the afternoon in case they were needed. The first officer said that during the debrief in A wing movements office he was specifically told to be aware of the prisoners' feelings, especially those on open F2052SH forms (those seen at risk of self-harm). The Suicide Prevention Co-ordinator, sent a memo to all group managers on 2 April, reminding them of the requirement in the Suicide Prevention Strategy that all prisoners who had an F2052SH form closed in the previous three weeks should be seen by staff. All prisoners on open F2052SH forms should have a full multi-disciplinary review. On 14 April, he sent a memo to the the head of the central business unit, confirming that these reviews had taken place.

Notices to staff and prisoners were issued on the afternoon of 2 April. The notice to prisoners was put under the door of each cell on A wing. The notice to staff advised those who felt they needed support to contact the care team or the senior management team. Prisoners were advised to ask any member of staff if they wished to contact their personal officer or a Samaritan-trained Listener.

A cooked meal was provided for the wing that evening. The meals were delivered to each cell by staff.

A police search team searched cell A3/02 on Saturday 3 April. On the outside of the window ledge, concealed by rubbish collected between the window and the mesh, they found a disposable plastic razor. The handle had been melted to allow a razor blade to be fixed to it. A second razor blade, which had been fixed to the handle parallel to the first blade, was recovered from the wounds on the man's throat during the post mortem examination. [Confirmed the police exhibits officer, in telecon with the Intelligence and investigations manager of the Yorkshire and Humberside Police 25 January 2005]

All staff received a thank you letter from the Deputy Governor on Tuesday 6 April. Unfortunately it has not been possible to obtain a copy of this letter. A Critical (or Operational) Debrief was held on 27 April. The Critical Debrief was arranged by the care team leader, and was attended by 12 of the 24 staff identified as having been involved at or away from the scene of the man's murder.

The first officer wrote to the Governor after 2 April to express his disappointment that staff who had been directly involved in trying to resuscitate the man had not been spoken to personally by governors. He said he received a typed response

from the Governor through internal mail. The first officer also complained to my investigators that none of the senior management team had attended the critical debrief on 27 April. The records appear to confirm this. The first officer also wrote to the Prison Officers' Association magazine *Gatelodge* to express his dissatisfaction.

In his reply of 16 April, the Governor said he was sorry that the first officer had thought the efforts of those who were first on scene were not appreciated. He thanked him for his efforts on 2 April and said that his Principal Officer would make arrangements to see him personally when she returned from leave. He said that the first officer would have an opportunity to air his grievances at the critical debrief.

#### **(vi) Family liaison**

At approximately 12.30, the Muslim chaplain said that the head of residence came to the chaplaincy room and told him that a serious incident involving a Muslim prisoner had occurred. He was not at this time the designated family liaison officer. He said he was taken to the hot debrief in the multi-faith centre where he learned that, although it was not officially confirmed, the man had died. Afterwards he went to the Governor's office to find out whether the man's next of kin had been contacted. It seems that at this point the Muslim Chaplain was asked to take responsibility for contacting the man's family. The man had given his wife's name as his next of kin when he first arrived at Leeds. The Muslim chaplain said that the Head of the central business unit retrieved the man's wife's name and contact details from LIDS (the Local Inmate Data System, a computerised system with information on current prisoners). The Muslim chaplain said he tried on at least three occasions from about 14.15 to contact the wife by telephone but each time there was no answer. In the absence of any other contact details for the man's family, the decision was taken by the head of the central business unit that he and the head of regimes learning and skills, would go to the wife's address.

The head of regimes learning and skills said that, at about 13.10, he was told that there had been a serious incident in the prison and made his way to the Governor's office at about 13.15. He said that the Governor and the head of the central business unit were already in the office. He said that the man's family contact details had to be obtained from his records in the Prisoner Administration department which is outside the main prison building. He remembered the Muslim chaplain trying unsuccessfully to contact the family by telephone. It was then decided that he and the chaplain should drive to the wife's home to break the news. He said that he and the chaplain left the prison at about 14.30. They had some difficulty finding the address and arrived at 15.50.

A statement made by both men shows that at 15.50 they visited the wife's house in Dewsbury and broke the tragic news of the man's death to his wife. The

Muslim chaplain said he spoke to the man's first brother on several occasions throughout the rest of the day, and visited the family again on 3 April. He said he had remained in telephone contact and on several occasions the man's first brother had visited his house. He also attended the man's funeral. The man's brothers visited Leeds prison and met the Governor on 21 April. They also attended Muslim prayers on Friday 23 April.

The Governor's contact log records that He spoke to the Muslim chaplain before his second visit to the man's family on 3 April. He asked the chaplain to convey his personal condolences and to ask the family if it would be appropriate for him to visit them. The chaplain told him later the same day that the family had said that, for the time being, they wanted to concentrate on the funeral. On 4 April, the Governor spoke to the police family liaison officer and, after some brokering, he visited the man's brothers. He offered his personal condolences and those of the Director General of the Prison Service. The Governor said he explained the process of investigation and offered the family ongoing contact and support.

The Director General of the Prison Service wrote personally to the man's family on 2 April.

### **(vii) The experience of the man's family**

At my meeting with the man's family on 29 April 2005, I agreed to include a written statement of their experiences. I received this on 8 August and it is reproduced in its entirety below:

"On 2 April 2004, the wife left home at about 2.15 p.m. to go to town. She had wondered why her husband had not phoned her that day as he would normally do so at some point during the morning. At about 3.10 p.m. she picked up her children from school and by the time she got home it was coming up to 3.30 p.m. As she walked into her house her phone rang and it was her brother-in-law, the second brother, asking her if the man had phoned. She said that he had not called and asked her brother –in-law why he was asking. He said that he had heard that there had been a fight in the prison and that her husband was involved. (She later learned that some prisoners who were unlocked in the early afternoon made 'phone calls to friends and family in the area, so that well before 3.00p.m. rumours had spread throughout Dewsbury that the man was seriously injured.

Less than five minutes after the first call, around 3.30p.m., another of his brothers 'phoned her and told her the same thing, about a fight in the prison involving her husband. She started crying as she knew that something was wrong. She started looking for the number to call at the prison and by the time she found a 'phone number the second brother had already arrived at her house. Both tried ringing the prison. Eventually He got through and asked if his brother was okay, explaining that they had heard that he had been in a fight and was injured. The person who answered the call told him that someone would call them back in 5 minutes.

While the second brother and the wife were waiting for a 'phone call back from HMP Leeds there was a knock at the door. Two men were outside and she immediately knew that something was seriously wrong. They came into the house and stood in the middle of the room and said that they had some bad news and that her husband had been involved in a fight and as a result had been killed. The two gentlemen left the house five minutes later, saying that they were sorry. At about 3.50 p.m. two police officers came to tell her what had happened. She cannot remember what they said as she was in a state of shock.

The widow does not understand why she was only told of what had happened in the prison more than 2½ hours after the events. The family now knows that by midday on 2 April 2004 a very large number of staff at HMP Leeds were aware of just how seriously the man had been injured and rumours reached the community well before contact was made with his wife. How did it happen that by noon it had not yet become an urgent task of one member of staff to notify the family that the ambulance service had been called and that the man was being taken to the hospital with very serious injuries? That is information that the family believes they were entitled to know very soon after noon on 2<sup>nd</sup> April 2004. Instead, the man was pronounced officially dead at 12.58 p.m. and yet the family were none the wiser at that time, when they should have been at the hospital already.”

#### **(viii) The post mortem report**

A post mortem was carried out at Pinderfields Hospital on 2 April between 19.05 and 21.30. A second examination was carried out on 8 April, also at Pinderfields Hospital. The post-mortem doctor carried out both examinations.

The cause of the man’s death is recorded as “multiple injuries”. He suffered lacerations to his head caused by impacts with a blunt instrument or impacts against a firm surface and incised wounds of the neck and ear caused by a sharp edged weapon. He was also strangled with a ligature – most probably the flex from the television aerial – and suffered a fractured jaw. The toxicology report did not show the presence of any drugs in his system.

### **Section three: Risk assessment**

#### **(i) Cell Sharing Risk Assessment (CSRA)**

The Prison Service introduced a national cell sharing risk assessment system in 2002. Its origins lay in a judgement by the European Court of Human Rights in a case brought by the parents of a murdered prisoner. The court found that the Prison Service was in breach of article 2 of the European Convention on Human Rights (ECHR) in that it failed to have in place an adequate risk assessment procedure. The murder by his cellmate of Zahid Mubarek in 2000 alerted the Prison Service to continuing weaknesses in its ability to risk assess and track potentially violent prisoners who should not share cells with other prisoners.

The risk assessment system introduced by Prison Service Instruction (PSI) 26/2002 sought to:

- draw together and pool information about risk from operational and health care staff
- make best use of documentary evidence

- support staff judgements about allocation to cells
- where cell sharing is unavoidable for a high risk prisoner, provide for senior managers to decide and record additional operational precautionary measures
- provide a readily accessible record about risk of harm to others as a prisoner moves between wings/prisons
- record decisions about managing and reviewing risk to enable early identification of racist, homophobic or violent prisoners to ensure that other Prison Service procedures to protect potential mans are followed.

The form it introduced (XF001) was intended to be a live document and to be revisited whenever a prisoner's location was being considered. PSI 26/2002 states that a review of prisoners with ratings other than 'high' need only take place when a prisoner is transferred, is having his cell location changed, or there is a change in the prisoner's circumstances. Part two of the form (XF002) should be used for this purpose.

According to the User Guide issued with the PSI the levels of risk are:

- High – Clear indication of high level of risk that prisoner might assault their cellmate.
- Medium – No immediate risk, but situation will need to be reviewed regularly. (This rating may also be used where staff feel that there are some signs of risk but there is not enough information available to be sure. Staff are asked to note on the assessment form why they feel there are some signs of risk.)
- Low – No current evidence/indication of risk. Suitable for multi-cell location.

The Prison Service had further cause to revisit its policy on CSRA after the murder of another inmate in 2003 in Manchester – a case I investigated myself. The Prison Service formed a working party consisting of Governors and staff from Safer Custody Group who were asked to consider the cell sharing risk assessment process and the broader context of risk minimisation. It was reported to the working party that some staff had found forms XF001 and XF002 to be unwieldy and unworkable in practice. The review also highlighted the particular problems faced by local prisons facing a high number of receptions and a strategy for these prisons was to be given priority.

One outcome of the review was the introduction of a risk minimisation plan. This is a live document designed to work on reducing identified risks. The review also gave responsibility for the risk management process to the Safer Custody officer in each prison. Part of their role is to provide on-going risk assessment relating to cell sharing. The review stipulated that a register of high risk prisoners should be held centrally in each prison to provide a reference point and an audit trail of open and closed cases.

A new PSI on risk assessment was published with new review forms and a risk management template on 29 July 2005. The Prison Service will keep cell sharing risk assessment under review until the outcome of the Zahid Mubarek Inquiry.

## **(ii) Cell Sharing Risk Assessment at Leeds**

Instructions on the new cell sharing risk assessment process were first issued at Leeds in Governor's Order 123/01. A further Order, number 8/02, was issued on 1 October 2002 by the Governor. The Order reiterated the purpose of CSRA and highlighted what was expected of staff when completing forms XF001 and XF002. The Order stated that, if a prisoner was judged to present a high risk to others, the duty governor and orderly officer (Oscar 1) would make a decision on the prisoner's location. If medium risk was indicated, then the duty governor and Oscar 1 should be consulted and a decision made on available evidence.

Order 8/02 gives guidance on how and when to complete the various sections of XF001 and XF002. The guidance for section seven of XF002, which should be completed when a prisoner changes cell, states:

“Section 7 should be completed:

- At three monthly intervals (until he is assessed as low risk) [NB this refers to high and medium risk prisoners]
- When there has been a significant event (assault on another prisoner, member of staff etc)
- When a prisoner is transferred to another prison.”

Since the murder of this man each residential unit holds a list of their prisoners' CSRA forms and a record of when reviews are due. Wing managers undertake reviews at present but it is intended that residential managers will initiate future reviews. I am also told that staff are working on a protocol that will ensure the use of available documentation when completing CSRA reviews, rather than simply relying on the prisoner's input.

## **(ii) The assessment process applied to the defendant**

The defendant's prison record (F2050) shows that he was the subject of a CSRA on five occasions after 2002 when the process was introduced. Mr McCann's first CSRA was completed at Leeds in September 2002 when he was remanded on charges of burglary and theft. Section One shows that the form was completed with the aid of the Prisoner Escort Record (PER) and the warrant. The defendant's pre-convictions and pre-sentence report (it is unlikely there was one at this stage) were not available. Question one of section two refers to previous convictions for violent or other serious offences against the person or any schedule 1 offence. The 'no' box is ticked and the source of the information is recorded as "I" to signify 'inmate'. In fact, the defendant had a conviction for Assault Occasioning Actual Bodily Harm in 1995. He also had a conviction for Wounding With Intent To Cause Grievous Bodily Harm in 1999, a schedule 1

offence because his man was under 18 years of age. Question four of section two relates to anti-social behaviour "if the prisoner is known to the Prison Service". All of the boxes are ticked 'no' and the source is recorded as the 'inmate'. The defendant's conviction for wounding resulted from his assault on a fellow prisoner with a wooden mallet at HMYOI Hatfield and would have merited a tick in the box marked 'assault on others'. He admitted he had abused alcohol or drugs in the past and was currently dependent on them. He said he had not been subject to F2052SH procedures before when in fact he had, at Doncaster in 1998. (He took an accidental overdose of heroin in 1997. Policy at Doncaster dictated he was put on a F2052SH but he did not show any cause for concern and denied any need for form to be opened.) He was deemed to present 'low' risk and be suitable for sharing a cell. Section three, which should be completed by a member of the healthcare team, is blank.

The defendant's second CSRA took place in HMP Holme House on 9 November 2002. The record's officer completed the form and his offence is wrongly recorded as 'wounding'. In fact he was on remand for burglary. On this occasion the only document available to the record's officer was his warrant. The answer to question one of section two, about previous offences against the person, is ticked 'yes' with the source recorded as the defendant. The record's officer also ticked the yes box to indicate his current offence was one of those listed on the form, when it was not. Question four shows a tick in the box to indicate a previous 'assault on others' with the source as the defendant. The record's officer rated him as presenting a 'medium' risk. A member of the healthcare team completed section three. None of the boxes indicating particular signs of risk to others are ticked but the member of staff indicated that he should be regarded as presenting medium risk. (Healthcare staff are not allowed to enter a level of risk lower than that made by reception staff.) Section four, completed by the duty manager, states "no immediate concerns".

The defendant was next subject to a CSRA at Leeds on 4 September 2003. The CSRA Officer, who had the benefit of the PER, the warrant and a pre-sentence report, completed the form. The source for the answers to all of the questions on the form is recorded as the defendant. He did not say that he had a previous conviction for ABH, or a schedule 1 offence, or that he had assaulted at least one other prisoner or that he had been subject to F2052SH procedures. He did say that he was currently dependent on heroin. The CSRA Officer assessed him as presenting low risk. A Nurse Hotel 3 completed section three. She recorded that there was "insufficient evidence to give an opinion" on whether the defendant might be at risk of harming others and assessed his risk as low.

He was assessed again on 14 February 2004, also at Leeds. The reception officer indicated he had the PER and the warrant. Part A of the PER form recorded that the defendant was a heroin user and the risk category "drugs/alcohol issues" is ticked. The defendant said he had a previous conviction from the list given in section one but did not say he had assaulted anyone in

prison or been the subject of a F2052SH form. He was assessed as presenting a low risk. The member of the healthcare team who completed section three indicated there was insufficient evidence to give an opinion on whether He presented a risk to others and assessed him as low risk.

The defendant's most recent CSRA before the murder of his cellmate took place on in March 2004. He had been found in possession of a sharpened dinner knife at the hostel and returned to Leeds on remand. The reception officer completed the CSRA. The form shows that she had received the PER form and the warrant. The PER, completed by the police, indicated the defendant was "no known risk". The section 'Further information about risk' reads "States fit and well (ex-drugs user)". There was nothing on the form to show why he had lost his place at the hostel. Apart from confirming that he had previously been dependent on drugs, he answered 'no' to all the questions. She assessed him as presenting low risk.

The reception officer made a statement to the police and was interviewed by my investigators. She said she did not remember him as she dealt with numerous prisoners on a daily basis. She said that it was not unusual to receive only the PER and the warrant. In most cases, reception staff relied on the prisoner to provide the information needed to complete the form.

Nurse Hotel 3 completed section three of the CSRA. She indicated that there was "insufficient evidence to give an opinion" on whether the defendant presented a risk to others and marked him as low risk. At interview, nurse Hotel 3 said that he remembered her from when he last saw her, which was in the segregation unit in February 2004. Then she said he had been "quite paranoid". However at his CSRA she said he was "very cheerful, quite happy, very lucid, very reasonable, well mannered". She said she thought that his behaviour in the segregation unit must have been "an isolated incident". Although there was insufficient evidence to give an opinion, she said there were no indications that anything was wrong.

In addition to the CSRAs two Custody Care Plans were prepared for the defendant while at Leeds. Custody Care Plans are designed for prisoners who are new to prison and seek to identify and help with problems such as drug dependency. They are generated when prisoners enter prison on a new prison number. The care plan officer completed a Custody Care Plan on the defendant on 18 February 2004. She referred him to the CARAT (Counselling Assessment Referral Advice Throughcare) team because he was undergoing detoxification but had not seen a drug counsellor. She assessed him as presenting a medium risk for the purposes of work after ticking the boxes marked 'any offence of threats, assault or use of weapons', 'would the prisoner pose a risk to staff and others when using tools or implements?' and 'would the prisoner require supervision when working?' The care plan officer said she had known him for some three years and he had never presented as a problem to her.

The second care plan officer completed a second Custody Care Plan for the defendant in March 2004. He said that the defendant had seemed unwilling to answer the questions put to him and his attitude was “a bit funny”. He said he had known him on A wing from previous sentences and he did not remember him as a difficult person. In section 7, assessment for work suitability, he has ticked both yes and no in answer to the question ‘any offence of threats, assault or use of weapons’. He explained in interview that the defendant did not give him an equivocal answer to this question. He assessed him as presenting a medium risk in a work situation. He commented at the end of the plan that the defendant had a “poor attitude”.

### **(iii) Indicators of the defendant’s risk pre-2004**

His prison record shows that he was involved in, or was suspected of being involved in, five fights or other incidents of violence. The defendant described two other incidents, which do not appear on his record, during his interview with my investigators. I shall look at each in chronological order.

In his interview, he described an incident when he was 14 and a group of Italian children came to his school as part of an exchange. He said that he was playing football with them when he had a fight with one of the boys. He said that the fight was about “just football and he was speaking Italian and he spat at me”. As a result of this, the defendant said, he was sent to what he described as a “special school”. A pre-sentence report completed in 1999 suggests that he went to Armley Park special school because of learning difficulties. A pre-sentence report written by his probation officer says it was as a result of his increasingly poor behaviour.

In 1995, the defendant was convicted of Assault Occasioning Actual Bodily Harm (ABH). I have not been able to find details of this offence but it resulted in him being fined and paying costs. In March 2004, in an interview with his probation officer, he said that he had been acting in self-defence.

In 1999, he was convicted of wounding after hitting a fellow prisoner at HMYOI Hatfield over the head with a mallet and sentenced to an additional 12 months. The police liaison officer at Leeds, confirmed that the man had been hit about the head and body with a wooden mallet and had sustained a gash three inches long on his head. The pre-sentence report was based on the defendant’s version of events at the time. It states that he and his younger brother were taken to Hatfield following sentence for offences of burglary. The defendant’s brother told him that he was being bullied by another prisoner and he asked him to point out the perpetrator so that he could deal with him “in a similar bullying way”. On the day of the offence all three prisoners were in the woodwork shop. The defendant went up behind the man and struck him several blows to the back of the head. During the interview with my investigators, he said he was in the workshop when an argument started over which radio station prisoners were listening to. He said

that another prisoner was “mouthing” and threatened his brother, so he hit him with a mallet. The defendant said that he had never met the prisoner he hit before. He denied he was a hot-headed person and said he would not start a fight but he would protect himself.

He received a caution at an adjudication for fighting a prisoner in Doncaster prison in February 2000. The record of hearing shows that he was charged with fighting in the same month. The first hearing took place the next day. The defendant pleaded guilty to the charge and was asked why he was fighting. The record shows he said:

“I got a job in laundry he didn’t like it. I confronted him on Tuesday he said let’s sort it. I went in his cell on Wednesday morning to sort it out, he was sat on his bed making a roll up. He looked at me and went for me. I grabbed his hand because he was holding a razor.”

The defendant said he realised he had grabbed the razor and pushed the other prisoner off him. He said the Doncaster prisoner advised him to “sort yourself out” so he left the cell and returned to his own cell. He said that the Doncaster prisoner then came to his cell with another prisoner and hit him about the face before running out.

The hearing was adjourned for evidence from two prisoner custody officers (PCOs) and resumed on another day. The first PCO said, when he arrived at the Doncaster prisoner’s cell, the prisoner was “cut on his arms” and said that he had been “slashed” by the defendant. The second PCO said the defendant told him that “the blade” belonged to the Doncaster prisoner. The deputy controller said that he was satisfied that a fight had taken place but there was insufficient evidence to say who had used the “blade”. He said that the defendant’s presence in the other prisoner’s cell had caused the confrontation and he therefore found him guilty and gave him a caution.

A Report of Injury to Inmate form (form F213) completed on 2 February showed that the defendant had “small cuts” on his right thumb and middle finger and to his left arm.

The other prisoner’s record of hearing shows that he was charged with fighting in February. The Doncaster prisoner pleaded not guilty and indicated that he wished to call witnesses. He was asked why he had pleaded not guilty. He said:

“The previous night we had an argument. The next day I was on my bed. The light was on, the defendant was over me with a blade, he said I have a blade and I will use it. He swung at me and I tried to grab him. We struggled I pushed him out of the cell. I saw my shirt was cut, my arm had been cut and I was taken to the hospital. I had three sutures in the cut.”

A witness called by the Doncaster prisoner, said that he saw the defendant come out of the Doncaster prisoner's cell and went over. He said the Doncaster prisoner was in shock and there was blood on the floor. He said the Doncaster prisoner was holding his arm and they both went to tell the officers what had happened. The witness said he and the "wing rep" went to the defendant's cell and he told them "it's nowt to do with you. I have sorted it out." The witness said he did not appear injured but was angry and they left. The second PCO said he was in the servery when the incident happened and he was told by the "wing rep" that the Doncaster prisoner had been "slashed".

The Deputy Controller dismissed the charge against the Doncaster prisoner on the grounds that there was insufficient evidence to show who had used the "blade". The completed F213 completed showed that he had a cut two inches long to the back of his left upper arm and a small cut below his left eye. The cut on his arm required three sutures.

At interview, the defendant described how he had become involved in another fight at Moorland when he was 20 or 21. He was in Moorland between May 2000 and January 2001 but there is no record of this incident in his prison record. He said that another prisoner threatened a friend of his and they started fighting. The defendant said that he joined in and hit the other prisoner over the head with a tin of rice pudding.

In November 2002, while on remand in Leeds, he said that he was sitting in his cell with his cellmate when another prisoner came into the cell and tried to "tax" (steal) one of his CDs. The defendant said that he "stood up" and the other prisoner left the cell. Later, during the association period he said the prisoner "wanted a fight". He said that his memory was unclear but he thought his cellmate got a pool ball and assaulted the other prisoner. The defendant said that he too "whacked" him. A security summary dated reads:

"DL5441 attempted to assault HB9925 with a pool ball in a sock. JN4165 stepped in to stop the assault. It is believed that DL4341 was also involved (cellmate of DL5441)."

There is no other documentary evidence about this fight.

#### **(v) Defendant's fight with his former cellmate in February 2004**

In February 2004, while on remand on B wing in Leeds, the defendant had a fight with his cellmate, and was removed to the segregation unit. The B wing SO remembered that the defendant and his cellmate were both strip searched in the segregation unit because there was information that a weapon might have been used in the fight. No weapon was found. On his arrival in the segregation unit staff realised that, earlier the same day, the defendant had assumed the identity of his cellmate and attended an adjudication in his stead. He was charged with pretending to be his cellmate and also with fighting. Both charges were proved at hearings in February. There is little information on the charge sheet for either charge. At the hearing for the charge of fighting, the reporting officer's statement simply said that he had seen the defendant and his cellmate fighting in their cell. The defendant's history sheet is similarly unforthcoming and simply records that he was taken to the segregation unit after having been found "fighting" with his cellmate. The record of events completed in the segregation unit states that the defendant was taken there for "assaulting" his cellmate. When asked why he was fighting, the record of hearing shows the defendant said that he and his cellmate had "a disagreement". On the charge of impersonating his cellmate at an adjudication, he said he thought that the reporting officer had called his name out instead. When it was pointed out that he had told the officer his cellmate's name, he said he was hard of hearing. His cellmate was approached by my investigators and the police but declined to give an interview with either party.

In his interview, the defendant said that his cellmate had "started attacking me with a knife". He said he accused him of stealing his property and they started fighting. He described it as "a little fight" and said his cellmate banged on the door causing prison officers to come to the cell. They were both taken to the segregation unit where the defendant said he "got the blame". He said that the knife was plastic and had snapped during the fight when his cellmate had gone for his neck.

His cellmate was also charged with fighting and was due to appear at adjudication in February. The hearing was opened and adjourned because his cellmate was in court that morning. The charge was later dismissed when his cellmate did not return from court.

The defendant remained in the segregation unit until he appeared at Wakefield Magistrates Court in February and was bailed. While in the segregation unit, staff became concerned about his "extremely strange" and "bizarre behaviour" and opened a F2052SH form as a precaution. This is the form used to record staff concerns that prisoners are at risk of harming themselves. The prisoner is then watched more closely and the situation is reviewed regularly. The form remained open until he was bailed.

The B wing SO said that he remembered the defendant and his cellmate and being brought to the segregation unit after their fight. He said he was involved in “processing” the cellmate. The SO remembered that the cellmate was strip searched because they had been told that there might have been a weapon involved. He said no weapon was found on the cellmate. There is no record of whether their cell was searched but this is standard procedure. In the event neither prisoner returned to that cell. The SO said that later that afternoon staff told him that they were concerned about the defendant’s behaviour. He described him variously as “difficult to speak to”, “uncooperative”, “abusive” but also “normal”. He said an F2052SH was opened as a precaution and the defendant was placed in the cell with a camera in it so he could be observed constantly. He was also subject to regular checks by staff. The B wing SO said a decision was made to contact the Mental Health Inreach Team (MHIRT) but could not remember doing it himself.

The wing officer remembers the defendant as “not normally active in the way he was thinking and talking” and “very strange”. He thought he might have been bullied but could not get “any sense out of him”. He said that he and another Officer had spent about 10 minutes talking to him trying to find out why he had taken his cellmate’s place at adjudication that morning but could not get a reason from him. The wing officer said that the defendant looked stressed and:

“...the more you started to go on with him it was as if he was, I don’t know, either on drugs or withdrawing from drugs or in the process of being off his head on drugs to be honest. He just didn’t seem to know what were happening, he’d say one thing and then retract it and say another thing, you’d ask him if he were getting bullied, he’d say ‘yes’ and then say ‘no I’m not’ instantly after.”

The wing officer thought that the MHIRT had been contacted about the defendant that afternoon.

The second SO said she thought that the defendant had taken the place of his cellmate at adjudication because his cellmate wanted to go to his domestic visit instead of to the hearing. She described the defendant’s behaviour on the segregation unit as “erratic”. She said he was constantly moving around the cell, shouting and pressing his cell bell. She said at one point he tried to tie his medication to a line and send it to B wing. The defendant was given a total of four “strikes” - formal warnings from staff, which would affect his standing in the Incentives and Earned Privileges Scheme (IEPS). The strikes were for misusing his emergency cell light, shouting out of his cell and telling officers to “fuck off”. The second SO said she thought that he was on a detoxification programme.

Nurse Hotel 3 said that she completed a segregation unit safety algorithm (the form used to check that a prisoner is suitable for segregation) when the defendant was originally brought to the segregation unit at 14.00. She said he

was calm and settled when she completed the algorithm but later, when she completed the healthcare assessment required as part of the F2052SH procedures, he appeared to be agitated because he thought people were going to “get him”. She thought he might have taken a drug of some description because he was laughing and chuckling, then becoming paranoid and his eyes were glazed. She said she thought his behaviour had settled by the end of the evening of 20 February. She said this supported her belief that he had taken something earlier in the day and that it was working its way out of his system.

The defendant’s F2052SH review record shows that the form was opened because he was in “a distressed state” and displaying “bizarre behaviour”. The form records that he was making “bizarre comments” and appeared unaware of his situation. At 15.20, Nurse Hotel 3 noted that he was “extremely anxious and behaving oddly”. He was unable to have a rational conversation and appeared disoriented and confused. At 15.30, The B wing SO recorded that he was concerned about the defendant’s “extremely strange” behaviour and that healthcare staff were arranging for him to see the duty Medical Officer (MO). The defendant was placed in the cell with a camera and the B Wing SO ordered five checks to be made on him every hour. The duty MO saw the defendant at 16.50 and reported that there was “no indication for any self-harm”. He recommended the defendant be returned to a residential unit. He said he was “not mentally ill or depressed”.

The defendant was reviewed the next day, Saturday 21 February, at 11.45. The B wing SO, the second SO, nurse Hotel 3 and a second wing officer attended the review. The B wing SO noted that the defendant was not present because he was being abusive and aggressive to staff. The record shows that he was still behaving strangely and unpredictably and it was decided to keep him under observation and to contact the MHIRT.

On Monday 23 February, the defendant was reviewed again by the B Wing SO, the first SO, the deputy head of residence and the incident review nurse. An improvement in his behaviour was noted but the review said he continued to switch between being approachable and talkative to being agitated, aggressive and talking nonsense. The review also noted that the defendant was due in court the following day, which left little time for staff to work with him or for the MHIRT to intervene. The review panel thought that the defendant needed specialist help and scheduled a further review for Wednesday 25 February. On 24 February, he attended court and was released on bail. The PER form accompanying him indicated that he was considered to be at risk from self-harm. It did not indicate that the defendant had recently been involved in a fight.

The clinical team manager for Leeds MHIRT, confirmed in a memo to my investigators that they had no record that the defendant had ever been referred to them. My investigators were unable to find a copy of the defendant’s IMR for this period.

On 4 April 2004, following the murder of the man, the segregation unit began issuing a memo to wing managers when prisoners were returned to residential wings following a finding of guilt at adjudication for violence. The memo instructed wing managers to carry out immediate CSRAs on all such prisoners.

#### **(vi) The incident at the hostel in March 2004**

In 2004, the defendant appeared at Wakefield Magistrates Court on charges of theft and possession of a sharply bladed instrument. The police case summary describes this knife as a “lockable folding knife”. He was already on bail charged with the burglary of a car dealership and was remanded to a hostel in Leeds.

The defendant’s personal file from the hostel shows that he was seen at Leeds Addiction Unit in March. His care plan front sheet shows he had indicators for violence and intravenous injection but not for self-harm. He was prescribed a subutex detoxification programme consistent with a heroin addiction of between £20 and £30 of heroin per day. He completed this in mid March. He was urine tested during his detoxification and returned negative samples. His hostel risk screen showed he was considered a low risk to staff and others and at no risk of harming himself.

The defendant’s keyworker at the hostel, also completed an Offender Assessment System (OASys) report while he was at the hostel. She decided that he presented a medium risk to the public because he was a schedule 1 offender and had a “previous history of violence”. She decided he would present a low risk to other prisoners if he were in custody. She noted there was no evidence that he was suffering from any mental illness or that his offending history showed any evidence of racial motivation or hatred of other identifiable groups.

His keyworker told my investigator that, in March 2004, she was a trainee probation officer on a placement at the hostel. She said that OASys reports were designed to consider an offender’s lifestyle with the object of producing a risk assessment. At the hostel their primary use was as a tool to provide a risk management plan for the person’s time in the hostel. She said that, as a trainee, all her reports were double checked by her supervisor. She said that three main risk factors were identified in his case. The most significant risk factor was his misuse of drugs. Secondly, the report highlighted that he required activities to prevent him from being bored. Thirdly, it was recognised that he was a schedule 1 offender. The keyworker said she spoke to a probation officer in Wakefield and was told that his schedule 1 status was as a result of violence towards another prisoner in 1999. She said that the fact that this offence had occurred 5 years previously meant that it was seen as less significant than his drug use. She said that staff were made aware of the defendant’s previous violence so that they could monitor him.

His keyworker said that she had two meetings with him at the hostel about a week apart. On the first occasion she said he was positive, admitted his shoplifting charges and was willing to undergo detoxification. On the second occasion he denied his charges and appeared uninterested. She said that she next saw him when he was discovered with a knife. She thought the knife was a dinner knife that had been sharpened. She said she did not review his OASys report as a result of this incident because that would have been a matter for his probation officer, when she completed his pre-sentence report.

At 9.30 on a day in March 2004, a residential officer at the hostel said he went into the TV room and saw the defendant with what looked like a knife in his trouser pocket. He asked him to go to the office with him and on their way there he noticed the defendant trying to conceal something in his left hand. In the presence of his keyworker, the residential officer asked the defendant to empty his pockets and take his jacket off. He did this but no knife was found. The keyworker said that, when the residential officer questioned the defendant about the knife, he denied that he had one and became abusive. The residential officer then called the police so that a proper search could take place and told the defendant to pack his bags as he was withdrawing his bed. The police arrived and searched him. They found a knife concealed down his trousers. The residential officer said he recognised the knife as similar to the dining knives at the hostel but said that this one had been deliberately sharpened to a point.

The defendant said in his interview that he took the knife because:

“There was a black lad in the hostel and someone had said something that he'd broken one of the doors off and he was, you know, robbing the rooms and stuff like that. Thought I'd put a knife in my room, it was only a butter knife as well...”

He said that it might have simply been a rumour that the other resident was stealing from people's rooms but “you can't tell can you?” He said:

“Nobody tell you do they? Nobody tells you anything what's happening. So you've just got to sort it out yourself.”

The defendant was taken to Leeds prison and appeared before Wakefield Magistrates in late March. He was remanded back into custody in HMP Leeds.

#### **(vii) The defendant's pre-sentence report and the Security Information Report of 1 April 2004**

On 31 March, his probation officer, interviewed him in Leeds prison for the purposes of a pre-sentence report relating to the charge of burglary on a car dealership. In compiling her report she also had access to papers from the Crown Prosecution Service, a list of previous convictions and sight of Probation Service records relating to supervision between May 1999 and June 2003. She also spoke to staff at the hostel and to the defendant's previous supervising officer.

In her report, the probation officer said that he told her that, when he committed the offence, he was carrying a knife for his own protection. She said he was unable to tell her where or from whom he perceived there to be a threat. She judged that he presented a medium risk to the public given his two previous convictions for violence and the fact that he had been in possession of offensive weapons on two occasions in the previous month. She added:

“His view of violence and carrying weapons is that he is protecting himself. In my opinion, those most at risk are likely to be other offenders whom the defendant perceives to be provoking or threatening him. This risk is raised when proximity is enforced such as in a prison or hostel environment.”

Following the interview, she updated his OASys report on 31 March.. She noted that his recent tendency to carry a knife was a concern, particularly as he could not say whether anyone had threatened him. She said that he told her he had argued with another resident at the hostel and this was why he had taken the knife for protection. She said that the defendant would not say much about his previous offences of violence beyond the fact that he saw it as a response to provocation and self-defence. She said he spent the interview with his hand over his mouth, did not answer some questions and would not engage. (This is entirely consistent with the experience of my investigation team when they interviewed the defendant in HMP Wakefield on 6 April 2004.) In section R8 of the Risk of Harm screening, the probation officer indicated that the defendant could be a serious risk to others. She noted:

“Assault with a weapon if feeling provoked. Could be that he either feels vulnerable when in criminal justice institutions and perhaps reacts out of proportion or perhaps is trying to set up a reputation. Or it could be that he is trying to protect himself albeit inappropriately. But he is not willing to talk about it and this is unclear.”

In section R11.12 Risk Management Plan, the probation officer wrote:

“liaise with prison re risks and inform of concerns re assault on prison inmate and possession of knife for protection at hostel. Suggest regular checks to ensure he has not obtained a weapon.”

The West Yorkshire probation area contact sheet shows that his probation officer telephoned Leeds prison on 31 March. She spoke to the discipline office and was told to contact the security department. The contact sheet shows that she could not get a reply from either the security office or the probation department at Leeds. On 1 April, she again phoned the prison and spoke to the SO in the security department. She informed him of his schedule 1 status and told him that he had previously wounded a fellow prisoner. She also raised her concerns following the defendant's behaviour at the hostel and his reason for carrying a knife.

His probation officer told my investigator that she became aware that the defendant was a schedule 1 offender when she returned from her interview with him to complete the OASys report. She said she knew that he had been convicted of assaulting another prisoner in 2000. She was concerned by this and decided to phone Leeds prison to pass on the information. She said she tried on several occasions on 31 March but could get no reply from the extensions given for the probation and prisoner administration departments. She tried again on 1 April and was advised by the switchboard to speak to the security department. She said she spoke to the SO in the security department sometime in the mid-morning of 1 April. She said that she regarded the defendant as a medium risk to staff and prisoners. Her expectation in passing on the information was that prison staff be aware of it, monitor his moods and take whatever action they thought appropriate. The probation officer said that she did not believe that the defendant was an imminent threat to staff or prisoners and, had she done so, she said she would have assessed him as high risk.

SIR number 649/04 showed that the security SO received a telephone call from the probation officer at 11.30 on 1 April. She told him that the defendant was a schedule 1 offender, because he had wounded another prisoner on a previous sentence in a YOI. She did not know which YOI he was in but gave the conviction date in April 2000. She also told him that he had lost his place at his bail hostel on the previous Friday because he had concealed a knife from the kitchen following an argument with another resident. The security SO completed sections 1–3 of the SIR and passed it to the security office at 11.40. A security administrator, completed sections 4–7 of the SIR at 10.30 on 2 April. She completed the evaluation section to indicate that the source was 'known to be a true source' but was 'untried', rather than 'very reliable', 'reliable' or 'unreliable'. The 'consequence code' section is left blank. The security administrator indicated that she had looked on the defendant up on LIDS to search for related intelligence but had found none. Section 8, for the security manager's comment, is blank.

The security SO said he received a telephone call from the probation officer on 1 April. He said she told him that the defendant had lost his place at a bail hostel for concealing a knife after an argument with another resident and also that he had a previous conviction for wounding. He said he completed a Security

Information Report (SIR) and passed it to the administrative staff for processing. As he was the person who opened the form he would not see it again. He said that the information provided by the probation officer did not cause him sufficient concern to take it immediately to his security manager. He said that there would need to be supporting intelligence to warrant this and the information would need to indicate a high level of risk with immediate consequences (consequence code 'HH'). In his opinion, the information from the probation officer did not fall into this category, which meant that the target for processing it would be 72 hours.

The security administrator said that she remembered the security SO completing a SIR on the defendant on 1 April after receiving information via a telephone call from the probation officer. The security administrator said that in April 2004 Leeds security department were processing about 50 SIRs per week. There were two staff, herself and another administrator, employed to provide the intelligence officer's assessment for each one. She said that she examined sections 1 and 2 of the SIR and noticed that there was no verification of the probation officer's identity. She noted that the Senior Security Officer had written in section 2 that the defendant had been convicted of "wounding another inmate (conviction date 14/4/2000)". She said she logged onto LIDS to confirm current information about him and also accessed IIS (the Inmate Information System) to check for background information from his previous sentences. She said she identified two YOIs that the defendant had been allocated to in 2000 and rang the security departments in both. She remembered that Doncaster was one of them but could not remember the other. Neither YOI had any record of the defendant being involved in a violent incident. The security administrator was told during her interview that the incident the probation officer was referring to actually occurred in 1999, although he was convicted of the offence in April 2000. She said that, had she discovered that the defendant had previously been involved in an incident of violence towards another prisoner, she would have sought advice from her manager as to whether a 'H/H' marking was appropriate. She said she would also have alerted the relevant wing manager to her concerns. However, as at the time she could find no evidence to corroborate the probation officer's information she completed sections 4-7 and passed the form to the SO's in-tray at 10.30 on 2 April.

The duty governor said he helped the head of the central business unit collate information about the man and the defendant on 2 April in the aftermath of the murder. He said he recognised the defendant's name from a partly processed SIR and went to find the relevant document in the security department. He said he phoned the probation officer to confirm some of the details and finished processing the SIR. The duty governor said that the information provided by the probation officer was not sufficient to place the SIR in the highest risk category ('HH'). He said that the information was "sketchy" and required further investigation. He said that it was not unknown for prisoners to have previous convictions for violence. He said that a normal course of action on receipt of this sort of information would be to recommend a review of the prisoner's CSRA.

### **(viii) What other prisoners said about the defendant**

The defendant's former cellmate was visited by the police after the murder. He agreed to give only a verbal account to the Detective Constable Police Liaison Officer. The former cellmate said that, during the time he shared a cell with the defendant in February 2004, the defendant talked to himself regularly. He said that the defendant appeared to talk to someone through a crack in the door even though there was no-one there. He said that one day he was sitting down writing a letter when the defendant jumped off the bunk bed and attacked him with a homemade knife. The defendant attacked his cellmate from behind and stuck the knife into his left cheek. The cellmate said he fought back and was able to raise the alarm by kicking the cell door.

The first inmate said he knew of the defendant through mutual friends. He described him as "quiet" and a "loner" who wouldn't tolerate anyone "taking the piss" but would "sort it out". He said he did not think the defendant was a bully or would "go out looking for trouble" but he wouldn't want to be in a cell with anyone who was "in his face". He did not think the defendant was violent although he had heard rumours that he had threatened his cellmate on B wing with a plastic knife.

The second inmate shared a cell with the defendant on the night of 25 March 2004. At interview he said that the defendant appeared "blank" and did not listen or reply appropriately to anything he said to him. He said that the defendant appeared a little bit paranoid and kept going to the cell door as if someone were coming. The second inmate said he thought that the defendant had mental health problems. He said he thought he was "slow" and would be a target for bullies. He said he felt "a bit uneasy" with him but not in danger.

The defendant then shared a cell with another prisoner. He described this man as "an Asian kid" and said he was "alright for an Asian kid". Prison records show that the defendant shared a cell with a third Inmate from 26-31 March. The third Inmate was a fine defaulter and his ethnic code is recorded as white. He was released from Leeds on 31 March 2004. The police interviewed him on 14 April 2004. The third inmate said he found the defendant "strange". He said the defendant smoked cannabis and made funny noises, sometimes laughing for no reason. My investigator spoke to the third inmate at his home address in June 2005. He said he could not remember what wing he was located on. He could remember a couple of the people he shared a cell with but did not remember the defendant's name. He did not recognise the defendant from a detailed description.

The fourth inmate shared a cell with the defendant between 31 March and 2 April. At interview with my investigators on 7 April, he said that the defendant seemed confused, talked to an imaginary friend and pointed at the cell door. He

said that the defendant told his imaginary friend that he had “slashed his last pad mate’s throat”. The fourth inmate said the defendant stared at him “like he was stoned” and had “no emotion in his eyes at all”. In the exercise yard, the defendant did not speak to anyone but rocked on his heels. The fourth inmate said that he thought the defendant had been “close to flipping” and would have “flipped if someone had been on his case”. When he moved to B wing on the morning of 2 April, The fourth inmate said he told two members of staff in passing that the defendant “wanted watching” (although he said he did not mention him by name). He added that he was more concerned that the defendant would harm himself.

In his statement to West Yorkshire police of 27 April, the fourth inmate said he found the defendant’s behaviour unnerving because he always seemed to be standing behind him or to the side. He said that whenever he turned around the defendant was staring at him. He said his behaviour became worse on the second day he shared a cell with him. The defendant spent more time walking around the cell and staring at him. He said that the defendant started talking at the cell door. He said the defendant had told him that he could tame wild bears and that he had “stabbed or slashed a padmate in the past”. The fourth inmate said that friends of his who saw the defendant behaving oddly on the exercise yard told him, “he will do you in that one”. He was so disturbed by the defendant that he made him sleep on the top bunk and turned his bedding around so that he could see across the cell. The fourth inmate said that he thought the defendant was mentally ill and that he might harm himself or someone else.

He said that the defendant had been in his sight except for a single 10 or 15 minute period during association on 1 April and for a period of about 40 minutes on the morning of 2 April. He said he left the cell to sort out an education course and when he returned the defendant was sitting on his bunk with his belongings packed. He said that the defendant had been allocated to A wing but he could not tell whether the defendant was happy about this because his face was expressionless. When the defendant left, the fourth inmate noticed he had left a razor in the sink. He said he had given two razors to the defendant and he thought he had only left one behind. He said he also noticed that the defendant had swapped his plastic knives. He said his had been clean and the defendant had left him with two that had been burnt at the ends so the plastic melted. The fourth inmate confirmed that the defendant had not collected any prescribed medicine on the days he shared a cell with him, nor had he smoked drugs. He said that he was so concerned about the defendant that, when he moved to B wing that morning, he told two officers on D2 landing, “you want to watch my last padmate, he’ll either harm somebody or himself”.

## **PART 2: Conclusions, Consideration and Recommendations**

### **Section one: The murder of a man and the prison's response**

#### **(i) The discovery of the man and the attempt to save his life**

The evidence shows that the man's screams were heard first in the segregation unit some two floors below his cell, where the alarm was immediately raised. My investigation team discussed the possibility of conducting acoustic tests on A wing with the police. The chances of replicating noise levels with any degree of certainty and accuracy was deemed to be virtually impossible so tests were not undertaken. (My team was also concerned should 'mock' screams be heard by staff and prisoners present at the original incident.) Statements taken from the inmates in the cell next door show they heard nothing. The first inmate said he had his music on loud because he was working out. The Muslim chaplain was in the chaplaincy room, which is located on the centre and abuts cell A3/02, for a significant part of the morning of 2 April. He did not hear any screams. The accompanying SO commented that noise seems to echo down to the segregation unit. He said that staff on this unit often call up to wing staff after having heard noise on the wings. The first wing cleaner was in his cell on A3 and did not hear anything. Lunch was being served to the prisoners and there was considerable noise on the wing.

Despite the short delay in getting to the man's cell caused by staff being alerted from the landings below, the response was swift. Nursing staff arrived within a few minutes. The HCO, who relieved the movements officer Alpha 7, is a qualified EMT. The ambulance staff arrived on the wing within 25 minutes of being called. Efforts were made in advance to ensure that the ambulance had the quickest possible journey out of the prison. This was good practice.

I commend all the staff for the attempts that were made to save the man's life. I particularly commend the movements officer Alpha 7 who happened upon a horrifying scene and proved by all accounts to be immensely professional and capable. I note especially the praise he received from the qualified nurses who attended.

When questioned, staff said they were happy with the medical equipment they had apart from the suction pump, which was old and not very easy to use. Tragically, the man's injuries were so grave that only a surgeon with supplies of replacement blood would have had any hope of saving him. I do not believe that staff could have done anything more to save his life.

Nevertheless a more detailed examination of the attempt to save the man's life can be found in the Clinical Review. The doctor that wrote the Clinical Review highlights important areas in which improvement in practice could be made

although he accepts that, even had these been made at the time, a different outcome was unlikely. I endorse the doctor's recommendations and have added them to my own. (The doctor's recommendations are the final four in the list below.)

**If he has not already done so, I recommend that the Governor of Leeds considers if individual members of staff, particularly the movements officer Alpha 7, should be acknowledged through the Prison Service's Performance Recognition Scheme.**

**I recommend that Leeds purchase updated suction pumps, which are easier for staff to operate.**

**I recommend that staff in prisons use a recognised code when calling for ambulances so that paramedics are aware of the nature of the incident they are attending and the right sort of ambulance staff is dispatched.**

**The quality of note keeping in the Inmate Medical Records at Leeds needs to be substantially improved.**

**A policy should be developed for the management of serious clinical events.**

**All healthcare staff should regularly practise basic life support including airway management.**

**Medical officers should be trained in Advanced Trauma Life Support.**

#### **(ii) The prison's immediate response to the murder**

Members of the senior management team began gathering in the Governor's office on the Centre at about 12.50. The duty governor, said that he waited until the man had been taken from A wing by ambulance staff and then, after a short conversation with the PO Oscar 1, went to the Governor's office. We know from the control room log that the man left the prison at 12.40. We can reasonably expect that the duty governor entered the Governor's office at about 12.45 or 12.50. The head of residence and the head of the central business unit, the other managers who accepted responsibility for decision making during the aftermath of the man's death, were either already there or joined him there shortly afterwards. The Duty governor and the head of the central business unit. They both agree that they began working through the death in custody contingency plan and gathering information on both the man and the defendant. The duty governor and the head of the central business unit agree that the head of the central business unit took responsibility for completing the action checklist from the death in custody contingency plan. It is generally agreed that the plan

was activated before the prison received confirmation at 13.05 that the man had died.

There is some evidence to show that around this time the head of residence, the Governor and the duty governor began to gather staff together for a hot debrief. The Muslim Chaplain said that the head of residence came to the chaplaincy office and told him about the incident and that he was taken to the hot debrief in the multi-faith room. He remembers that the head of residence told him at 12.30 but this is clearly too early as the head of residence did not enter the Governor's office until after the duty governor at 12.45. The HCSO said that he helped take the man to the ambulance at 12.40 and then collected the nursing staff and returned to the treatment room. There they washed their hands and then moved to the healthcare centre clinical room where they had a quick debrief of their own. He said that the duty governor came to the room and told them that there was to be a hot debrief. They went to the multi-faith room and were the first staff to arrive. The HCO confirmed that the nursing staff had time to write their statements as well as have a quick debrief in the clinical room. The A wing log kept by the incident log officer shows that the duty governor was on the wing between 13.05 and 13.07. The action check list records that the new race relations liaison officer informed the Area Manager of the man's death at 13.15. (The Area Manager was actually in the prison at the time on his first visit since taking up the post. The Deputy Governor was escorting him.)

The PO Oscar 1 said that the head of residence led the hot debrief which lasted about 20 minutes. The record of attendance shows that the head of the central business unit, the duty governor and the new race relations liaison officer were also there from senior management. The PO Oscar 1 said that, following the hot debrief, the head of residence went to A wing to give a hot debrief to the staff who were being kept separate for forensic purposes. The movements officer Alpha 7 confirmed that the head of residence, the deputy head of residence and the new race relations liaison officer came to see him in A wing office for this purpose. The A wing log shows that head of residence and the deputy head of residence were on the wing between 13.47 and 14.02, and that the new race relations liaison officer was on the wing between 13.52 and 14.02. The log also shows that the muslim chaplain was on the wing between 13.52 and 14.03.

The hot debrief must therefore have taken place at some point between 13.15 and 13.47. The head of the central business unit confirmed that his first contemporaneous entry on the action checklist was timed at 13.50, which is consistent with this timing. The head of residence remembered the debrief occurring at about 14.00 but clearly he was on A wing at that time. Given the short distance from A wing office to the Centre, he probably returned to the Governor's office at about 14.04 and the muslim chaplain followed him at about 14.05. It is apparent that the chaplain was at this time asked to contact the man's next of kin. The action checklist records that the chaplain was appointed at 14.00. He remembers that the head of the central business unit retrieved the family contact details from the man's record on LIDS. He recalls making "at

least” three phonecalls in quick succession at around 14.15. As these were unsuccessful, it was decided that the chaplain and the head of regimes learning and skills would drive to the contact address and await the family. They left at about 14.30.

It appears that, during the attempt to save the man’s life and in the aftermath of his death, no single manager assumed overall responsibility for taking control of the ‘incident’. On 2 April, a governor was designated duty governor and a principal officer was designated orderly officer, Oscar 1. It is common practice that during an ‘incident’ the duty governor assumes initial command of the situation, usually from the control room or other communications centre. The orderly officer is required to attend the scene and direct procedures from there. In this case both the duty governor and the PO Oscar 1 and attended the scene on A wing. The Deputy Governor said that he co-ordinated the response to the murder from the Governor’s office. The interviews with the duty governor, the deputy head of residence and the head of residence do not specifically refer to his role.

When serious incidents occur, there is always confusion, uncertainty and shock. Following the murder of the man I am not clear that there was sufficient overall management of events. I am especially concerned by the length of time before anyone tried to contact the man’s family. The prison was told at 13.05 that the man had died but the chaplain was not appointed to contact the family until at least an hour later. This is unacceptable. Given the serious nature of the man’s injuries, I think that a member of the senior management team should have taken responsibility for trying to contact the next of kin immediately the man was discovered with such serious injuries.

I am pleased that staff decided to travel to the family home in an effort to make sure they were the first to break the news. Given the length of the journey it would also have been prudent for someone to have continued to try to contact the family by telephone. I note as I have in other investigations that a problem surfaced because there was only a single next of kin on the man’s record. Unfortunately, when only a single name is given, this can cause delay when they cannot be contacted.

When I met members of the man’s family on 29 April 2005, they expressed concern that contacting the family appeared at number 22 on the action checklist. I accept that this list is not intended to reflect a hierarchy with the most important contact at number one. I also accept that, in practice, there are usually several staff tasked simultaneously with contacting the names on the list. Nevertheless I believe that contacting the family should be given the highest priority. This is not least because such news often makes its way out of the prison by other means and can result in families finding out about the death of their loved ones via the media or the local grapevine (as it did in this case). I note also that the Death in Custody contingency plans in operation at Leeds at the time place the next of kin

third on the list of persons to contact. Clearly these contingency plans were not followed on 2 April.

**I recommend that the Governor amends Leeds's death in custody action plan to emphasise that the next of kin should be contacted as a matter of urgency.**

**I recommend that the Prison Service gives consideration to extending the next of kin provision on LIDS to include contact details of other significant persons.**

**I recommend that family contact details should be reviewed on a regular basis, and that prisoners should be reminded to keep them up to date.**

### **(iii) The care offered to staff and prisoners**

I am pleased to see that the other prisoners on A wing and in the rest of the prison were told quickly about the death of the man and that staff visited those prisoners who should have had visits personally to explain what was happening. Muslim prisoners also received a personal visit to explain why prayers were cancelled. I am also pleased that the required attention was paid to prisoners subject to, or recently removed from, F2052SH (self-harm) procedures. Prisoners were more generally advised to ask any member of staff if they wished to contact their personal officer or a Samaritan Trained Listener. I note from the first wing cleaner's experience that the Muslim chaplain and the Rev chaplain,, were also active in offering help to prisoners upset by the man's death. It seems that efforts were made to return the wing to normality as soon as possible.

All of the staff interviewed told my investigators that members of the Care Team contacted them on at least one occasion after the man's death. Most people said they were happy with the level of support offered, indeed some commented that they would have been happy with less. Nurse Hotel 3 and nurse Hotel 4 were happy with the support offered by their line management. I note, however, that the movements officer Alpha 7 and the first officer were unhappy that no senior manager spoke to them about their experiences. The movements officer was interviewed by the investigation team on 15 April 2004. He said that, since he had returned to duty, no staff above the rank of Senior Officer had spoken to him about the death of the inmate. He described the thank you letter he received from the Deputy Governor as a "standard" letter.

I have not inquired in depth into what the movements officer and the first officer have said. I simply draw their comments to the attention of Leeds's senior management.

## **Section 2: Risk Assessment**

### **(i) Cell sharing risk assessment in the Prison Service**

I had cause to examine the process of cell sharing risk assessment (CSRA) during my investigation into the murder of another prisoner at HMP Manchester in 2003. The death of that prisoner served to highlight weaknesses in how risk assessment is carried out in the Prison Service. I said then that reviewing risk assessment was a matter of urgency. In particular, the flow of information into prisons from agencies such as the Crown Prosecution Service and the National Probation Service needed to be improved. I also said that, given the size of the prison population, a large degree of cell sharing (and, necessarily, some risk of prisoner-on-prisoner violence) was unavoidable. I accepted that, even if the Prison Service were to come up with a system that was robust and workable, given the extent of compulsory cell-sharing, and the make-up of the prison population with its growing proportion of violent offenders, some risk would remain. Much that I said then is unfortunately still true today.

Risk assessment and the management of risk are not exact sciences but in order for them to work successfully the nature of the risk must first be identified. The identification of risk is a major difficulty faced by the Prison Service. Once risk is identified the Prison Service appears to have developed some strategies to monitor it. At Leeds my investigators saw good use of a 'high risk log' used regularly to bring high risk prisoners to the attention of group managers. This is direct evidence that the risk minimisation plan brought in by the review of 2003 has had an effect. The problem remains how to get information into the prison so that staff are able to identify risk. Until the problem of ensuring the flow of information into prisons is overcome the system will remain fundamentally flawed.

Research from RDS (Research Development and Statistics department of the Home Office) into the CSRA forms, under the direction of a working group including policy, research and operational staff, prepared for the Prison Service review in November 2003 showed that the information gleaned from the prisoner interview was only 45% accurate. The graded risk ratings were inconsistent and there was rarely any commentary to explain the nature of the risk identified. The report also showed that in only two fifths of cases (43%) where prisoners had relevant previous convictions did the CSRA form identify them. Interviews with staff conducted by RDS suggested that the amount of time and information available to officers in reception made the quality of the information on the form questionable. Staff were concerned about relying on information received from prisoners to complete most of the form.

As indicated by this research, staff are reliant on prisoners for most of the information gathered during the CSRA. In a local prison such as Leeds it is comparatively rare for a prisoner to turn up in reception with a pre-sentence report, OASys report or risk assessment information from a previous

establishment. The most common documents available to staff are the PER form and the warrant, which typically hold too little information to form a valid judgment on risk. For example, the PER for the defendant's most recent recall to Leeds before he murdered the man (after he was found with a sharpened knife in the hostel) has no information on it about the reasons for his breach of bail.

The CSRA review of 2003 recognised that arrangements needed to be made to get pre-conviction data to reception/induction staff on the first night. The review suggested that greater numbers of prison staff be allowed access to the Police National Computer (PNC) to obtain previous conviction data during the CSRA process. While this is a good idea it may be easier in the short term for staff involved in the CSRA process to be able to access LIDS and IIS. It was also hoped that OASys would provide more regular, more joined up information from the Probation Service to prisons. I am aware that OASys's 'connectivity' does not come on line until October 2005 but there is little evidence that prison staff in busy local prisons like Leeds are able to access to this data or use it as part of CSRA. I am told by the National Offender Management Service (NOMS) Safer Custody Group that from 2006 all prisons will have access to the police's Violent Offender and Sex Offender Register database (VISOR). It is recognised that reception staff will need to access this.

Given the pressure on reception staff caused by the numbers of prisoners arriving each day, and the absence of much documentation relating to them, it may be that the Custody Care Plans used in Leeds (which are done in a prisoner's first few days in prison) can be tailored to supplement the CSRA process. I have seen an example in another of my investigations where wing staff are responsible for completing risk assessments. I can see a lot of merit in a system where the staff who make the assessment then have a greater involvement with the prisoner, and can observe him or her on a day to day basis. Wing staff could also be required at a very early stage to read a prisoner's file including pre or post sentence reports and OASys reports.

As I noted in Part 1 Section 3(i) of this report, a new PSI (PSI 32/05) on risk assessment has now been published with new review forms and a risk management template. The subject of cell sharing risk assessment will be kept under review until the outcome of the Zahid Mubarek Inquiry. I am disappointed that this new PSI was not published until 22 months after the death of the prisoner that died at HMP Manchester and some 15 months after the death of this man in HMP Leeds. I welcome the direction in paragraph eight that the PER, warrant, probation reports, OASys and previous convictions must be consulted, if available, when the CSRA is being completed. I am pleased that paragraph 26 provides for reviews of a prisoner's risk assessment after a significant event and states that the OASys document must be consulted during this review. I also welcome paragraph ten which states:

“10 – A prisoner with a history of violence in custody (situational violence) presents a heightened risk... In compiling any subsequent risk minimisation plan and/or reviewing the risk assessment, a prisoner who has exhibited over-reactive behaviour in response to perceived threats or who is known to have armed themselves with a weapon whilst in custody, should be managed with extreme care.”

However, I am aware from many of my investigations how rare it is for staff to have the information listed in paragraph eight available on reception or for them to have the time to read it. I also believe that a more sophisticated approach to understanding the nature of violence and risk is needed within the Prison Service generally. The defendant did not present as a violent offender but he was violent in prison. The information which identified him as a risk to his peers was there in the documentation but was not seen. The current system relies too heavily on staff identifying a prisoner as violent by the nature of their offence. This is not necessarily an indicator of violence in prison. People who have committed the most terrible crimes can be model prisoners and petty thieves can become murderers in prison.

Staff given the task of making cell sharing risk assessments need time to gather and digest the documents listed in PSI 32/05. They need to know what information they are looking for. The Prison Service should re-evaluate the staff time devoted to risk assessment and provide additional training to those staff who are expected to carry out the process. I invite the Prison Service to consider these proposals during its consideration of any proposals emerging from the Zahid Mubarek Inquiry.

## **(ii) CSRA in Leeds**

The number of new prisoners received each month at Leeds runs into many hundreds. At the time of the man's death, the average stay was eight weeks. The sheer numbers and the transient nature of the population mitigate against the effective operation of CSRA.

In her interview the reception officer described the process from the point of view of the officer in reception. She said that she read out the questions on form XF001 “parrot fashion” for the prisoner to reply to. I am left with the impression of busy officers with several prisoners to process and a set of questions that has become routine.

As in the Manchester investigation, there was no use of the form XF002 and seemingly no awareness amongst staff that prisoners are required to have their CSRA reassessed when moving cells. In this investigation the evidence suggests that prisoners have their CSRAs checked visually by movements officers on both the sending and receiving wings but there is no auditable trail to show that this occurs. Leeds's Governor's Order 8/2002 on CSRA does not say

that CSRAs should be reviewed during cell moves. Moves appear to be arranged on a relatively ad hoc basis. The man and the other prisoner that moved from D wing to A both asked on the morning of 2 April if there was a chance of moving wings and both moved immediately because there happened to be spaces on A wing. This informal approach necessarily reflects the hundreds of cell moves that occur during a week in a busy local prison like Leeds. It reinforces the need for a CSRA process that can be workable in such an environment.

The defendant's CSRA of September 2002 was incomplete. I accept that the completion of CSRAs has since improved and the Governor should be vigilant that this is maintained. Similarly, when faced with a prisoner with a conviction or previous conviction for a violent offence, staff should be required to make the nature of this conviction clear. If the box is simply ticked, anyone looking at the form later will be none the wiser as to the specific nature of the prisoner's risk. I note that this is now a requirement of PSI 32/05.

Governor's Order 8/02 provided that prisoners should have their CSRA reviewed after significant events, for example an assault on another prisoner. Accordingly, before *the man* was murdered, procedures were in place at Leeds to ensure that prisoners found guilty at adjudication for assault had their CSRA automatically reviewed. Shortly after the man's death this was widened to include findings of guilt for fighting. Given that a fight is in fact a mutual assault, I am surprised that it was not previously deemed to have been an event of enough significance to warrant a CSRA review, particularly if a weapon were to be involved. Had it been deemed so earlier in 2004, it might have brought the defendant's propensity for fighting with his peers to the attention of staff. Nevertheless, I welcome this change. These procedures should of course be subject to regular management checks.

I also welcome the news that staff are working on a protocol that will ensure the use of available documentation when completing CSRA reviews, rather than simply relying on the prisoner's input.

**I recommend that a new Governor's Order is issued on the operation of CSRA in Leeds. Staff and managers should be made aware of their responsibility to keep CSRA an ongoing process throughout every prisoner's time in the prison.**

**I recommend the Governor satisfy himself that he has in place appropriately robust management checks that CSRA forms are completed in full at all times.**

**I recommend that the protocol being worked on at Leeds which ensures the use of available documentation when completing CSRA reviews is brought into operation as a matter of the highest priority.**

Below is a list of examples of reasons why nine current prisoners are rated high risk at Leeds:

1. A member of combat 18
2. Is displaying "bizarre behaviour"
3. Is awaiting outcome of psychiatric assessment
4. Is a prolific self harmer
5. Has superbug M.R.S.A
6. Has thoughts of killing pad mate, and also of killing his counsellor
7. Took his cellmate hostage
8. Two incidents of taking his cellmate hostage
9. Involved in a barricade incident

With the obvious exception of the MRSA superbug these are all behaviours that would probably not be picked up on first reception in the current system of risk assessment.

### **(iii) The risk assessment of the defendant**

The records show that the defendant had been involved in eight violent incidents before April 2004. Of these eight incidents four involved violence towards other prisoners. Of these prisoners, one was known to be black. On four occasions both inside and outside of prison, the defendant was known to be or accused of carrying a knife. He was risk assessed five times by the Prison Service between September 2002 and April 2004. In March 2004, he was also the subject of two OASys reports compiled by staff from the Probation Service. Some of these reviews noted that he had a previous conviction for assaulting another prisoner in a YOI in 1999. Only one, the OASys report written by his probation officer, concluded that his pattern of behaviour indicated that he posed a threat to his fellow prisoners. I believe that this serves to highlight two issues: the focus of the Prison Service on violence per se as a risk factor and the necessity of getting information from other agencies into the prison risk assessment process.

The CSRA user guide written by the Prison Service states that, "the most reliable predictor of future violence is a history of past violence". It follows that the most reliable predictor of situational violence is a history of past situational violence. I reiterate my belief that the Prison Service must look closely at how it views violence as a risk factor. A common opinion expressed by staff during this investigation is that the defendant did not stand out as a violent prisoner. There are countless prisoners in the system who have committed extremely violent offences and on the face of it would have appeared to be far more of a danger than the defendant appeared to be before he murdered his cellmate. Therein lies the problem of confusing the violence used when committing an offence and the violence demonstrated when placed in a custodial setting. The Prison Service

risk assessment process is simply not set up to recognise such a pattern of situational violence.

Analysis of the defendant's fights in prison reveal a striking similarity in his descriptions. He was 'on his own' and had to 'sort things out'. He regularly describes himself as the man who was 'stitched up'. He reacts to perceived threats but there is no real evidence of a threat existing. He is prepared to arm himself and to use a weapon.

The sad circumstances of the murder of this man also ably demonstrate how important information about risk is not transferred around the prison system, even when the prisoner returns to the same prison. The defendant arrived back in Leeds in March 2004. He had been previously released from Leeds in February 2004 on an open F2052SH form after a fight with his cellmate and a period of extremely strange behaviour in the segregation unit, which had resulted in a recommendation that he be referred to the MHIRT. Since then he had been charged with having a weapon in a public place and lost his place at a bail hostel for being found in possession of a sharpened knife. None of this information was available to the member of staff in Leeds who completed his CSRA. (I recognise that nurse Hotel 3 did his medical screening and she remembered him from his previous time on the segregation unit but this was quite by chance.)

Nurse Hotel 3 commented that it was a shame that the defendant returned to Leeds on a different prison number. This too presents a hindrance to relevant information on risk following a prisoner around the system. SO Alpha 1 commented that, because the defendant had come in on a new number, they had no information on him on the morning of 2 April when he was received onto A wing. I note too the B wing SO assertion that, despite all the worry over the defendant's behaviour in February 2004, staff from the unit would not have been involved in any CSRA should the defendant have been returned to a residential wing instead of being taken to court.

I am dismayed by the manner in which the information provided by his probation officer in her phonecall of 1 April was dealt with by staff. I do not take particular issue with the security marking accorded to the information but I do not think a SIR was appropriate as the sole medium for the probation's officer message. She did not believe that the defendant posed an imminent threat to other prisoners, but she did think he posed some threat and was concerned to pass this information on so that staff who dealt with him could monitor his moods. She was not ringing to instigate a SIR, indeed it was only because she could not contact the probation department that she ended up speaking to the security department. The probation officer is a criminal justice professional and had access to far more information on the defendant's likely risk than the prison. Whereas staff in the security department routinely process about 50 SIRs in any given week, it is extremely rare for a probation officer to call the prison to raise concerns about a prisoner's risk. I think that it would have been the right course

of action for security staff to ring the residential wing manager and pass on her concerns. I also believe that this information should then have been sufficient grounds for wing staff to initiate an immediate review of the defendant's CSRA. Wing staff could also have considered at this point whether it was appropriate to search the defendant for a weapon. In fact, the OASys report does say that he should be searched regularly for concealed weapons. I am inclined to think that staff should have requested a copy of this report as a matter of urgency.

I should add that I do not share the duty governor description of the information provided by the probation officer as "sketchy". She was quite specific that the defendant was a schedule 1 offender as a result of an incident in a YOI for which he received a conviction for wounding on 14 April 2000.

I consider that, based on the information available to staff at the time, the defendant was correctly assessed as presenting a low risk when he returned to Leeds in March 2004. However, the information available to staff was a woefully inadequate basis on which to make such a judgment. That said I do not think that prison staff would have put him at anything higher than medium risk had they been privy to all the information. That is because the risk assessment system at the time was not geared to recognising a history of situational violence. It is clear from the tragic events of 2 April that in fact the defendant was a high risk to his peers. As I have said, I welcome the changes made in PSI 32/05 which followed the Prison Service's receipt of an earlier draft of this report.

**I recommend that the Governor reminds all staff of the need for speedy and determined action when information relating to risk of harm is received from other criminal justice agencies.**

#### **(iv) The man's transfer to A wing and allocation to a cell with the defendant**

The process of cell allocation during wing transfers in Leeds is undertaken by the movements officer on the wing the prisoners are transferring from. The movements officer has a list of available cells and a list of prisoners due for a move. It is their job to match the prisoners to the spaces. Despite apparent contradictions in the interviews with the movements officer Alpha 7 and the D wing movements officer, the man and the defendant were allocated to the same cell by the movements officer on D wing.

Both the man's former D wing cellmate and the D wing movements officer agree that, on the morning of 2 April 2004, the man asked the movements officer on the off chance whether he could move to a different wing. The man had been encouraged to seek a transfer to A wing by one of his friends and former cellmate. (In fact the man asked if there was a possibility he could share with his friend when he arrived on A wing.) By chance there was a space on A wing and the movements officer agreed to the transfer. The other prisoner that moved

from D to A wing also gave evidence that he asked for a move to A wing on the off chance on the same morning.

I conclude that the placing of the man and the defendant together was a totally random decision. I have said elsewhere in this report that staff in Leeds prison were completely unaware of the terrible threat that the defendant posed to his fellow prisoners.