

**Investigation into the circumstances surrounding the  
death of a man at Hope Hospital, Salford,  
on in September 2008, whilst in the custody of  
HMP Forest Bank**

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

**September 2010**

The man (hereafter referred to as “the man”) was 35 years old when he died on 19 September 2008 at Hope Hospital, Salford. He had been the subject of a brutal attack at HMP Forest Bank. Three prisoners were originally charged with his death, and one was convicted. The prisoner (hereafter referred to as “the prisoner”) concerned pleaded guilty to manslaughter.

The investigator and Family Liaison Officer (FLO) join me in offering our sincere condolences to his family and friends for their sad loss. I wish to thank the Director of Forest Bank for making the necessary facilities and information available to the investigator. I also thank the prison’s liaison officer for her assistance.

As the circumstances of the man’s death have been fully investigated by Greater Manchester Police and in the prisoner’s trial at Manchester Crown Court, I have limited my investigation to events after 19 September 2008. However, for completeness, and by reference to police records, I do summarise the events of that day. For the purpose of this report and chronology, I begin the key findings section with the basic details of the prisoner’s movements within the prison system from 26 September 2006 when he was in custody at HMP Risley.

The man had been serving a three month prison sentence for breach of bail. It was his first time in custody. Under the terms of the End of Custody Licence (ECL) procedure the man was eligible for release on 15 September 2008. However, before anyone is released on ECL, further background checks are carried out on the Police National Computer (PNC) to ensure they fulfil the criteria. Forest Bank do not have their own PNC terminal, and instead have to request the information from HMP Hindley which is the designated reference point for Forest Bank and two other prisons in the area.

Unfortunately, at the time in question there were severe delays at Hindley in processing PNC applications. This caused a backlog of applications, including the man’s and meant that the PNC information did not arrive at Forest Bank in time for them to consider his suitability for release on the appropriate date. In an effort to speed up the process, and frustrated by the delays, the Director of Forest Bank had regularly sent a member of his staff to Hindley to collect any PNC documents that were ready. Sadly, when his check was finally collected, it was on the day he was assaulted. But for the delay in accessing PNC information, there is no reason to suppose he would not have been released on 15 September. It will be of no comfort to his family to learn this.

I make two recommendations. One is to the National Offender Management Service concerning the routine examination of back records. The other is for the Director of Forest Bank regarding the introduction of an audit trail for the recording of equipment failure and repair. Not surprisingly, my report also comments on the current position regarding individual prisons’ access to the PNC.

**Jane Webb**  
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**September 2010**

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## **SUMMARY**

On 20 August 2008, the man was sentenced to three months imprisonment after breaking the conditions of a supervision order imposed earlier that year. It was his first time in custody.

On reception at HMP Forest Bank he underwent a cell sharing risk assessment (CSRA) and was judged to be low risk for sharing a cell. Shortly after he was allocated to a cell, another prisoner joined him. Less than a month later, on 19 September 2008, that prisoner assaulted the man so badly that he died from his injuries. The prisoner had earlier been assessed in another prison as being a high risk to other prisoners if he shared a cell. However, he moved to Forest Bank after that assessment was made, and, on this occasion, had returned to custody after breaching the conditions of his release. Staff at Forest Bank did not have access to his previous prison record when he arrived, and did not refer to his previous risk assessments when they became available.

I conclude that the attack on the man could not reasonably have been predicted.

The man might have been eligible for release on 15 September 2008. Sadly, there were failures in accessing routine information. A PNC check was delayed as staff at HMP Hindley had a backlog of information requests, which meant the man's previous convictions were not properly assessed in time for his potential release date. This delay caused him to be kept in prison longer than he should have been under the End of Custody Licence (ECL) scheme.

Two recommendations are made in this report. The first is that the National Offender Management Service (NOMS) should consider issuing guidance advising Governors and Directors that, once back records are received, previous CSRAs should be checked and the most recent assessment reviewed. The second recommendation (which is directed to Forest Bank) should ensure that equipment faults are logged and rectified. I also comment on the issue of Prison Service access to the PNC.

## THE INVESTIGATION PROCESS

1. Once the Ombudsman's office was notified of the man's death, the investigation was allocated to a senior investigator. He was assisted by two Family Liaison Officers (FLOs).
2. On 23 September 2008, the investigator travelled to Forest Bank where he met the Director, the prison's liaison officer, the prison's Operations Manager and the Police Liaison Officer. The Director gave the investigator an overview of what had occurred.
3. Additionally the Director explained the difficulties he was experiencing in obtaining PNC checks and his own terminal. My investigator immediately reported to me personally about this issue and, because the investigation was to be suspended in light of the police investigation, my Deputy Ombudsman raised it at a high level with the National Offender Management Service.
4. Every death in prison custody is reported to the police as soon as it is discovered. In the first instance, the police treat the area where the person is found as a potential crime scene. When the police are satisfied that the death is not suspicious, PPO investigators are able to begin their own investigation.
5. The investigator shared a copy of the Memorandum of Understanding between this office and the Association of Chief Police Officers with the police officer in charge of the investigation. This document sets out the protocol for investigating deaths in prison and sharing information.
6. The man's death was not confirmed until he had been taken to Hope Hospital, Salford, and assessed. Following confirmation that he had died, police officers treated the incident and area where he had been found as a murder scene.
7. In agreement with the police investigators, my investigation was suspended pending the outcome of the criminal case. It was resumed only after the police confirmed that their own case had been concluded.
8. On July 2009 at Manchester Crown Court, the prisoner pleaded guilty to manslaughter. The police officer in charge of the case at that time contacted our investigator and gave him permission to recommence the investigation.
9. The investigator and FLO met members of the man's family and their solicitor. The purpose of the meeting was to identify any issues they wanted the investigator to consider. However, as the circumstances surrounding the assault and death had been fully investigated by police and subsequently explored at court the investigator told them that he would limit the scope of his investigation to events after 19 September. The man's family and solicitor agreed and have contributed towards the investigation. I am grateful for their assistance at what was a very difficult time.

10. On 19 August 2009, the investigator, FLO and two police officers from Greater Manchester Police attended a meeting in Bolton with the Coroner for West Manchester. The investigator shared the family's concerns and the revised scope of the investigation with the coroner. Following the meeting the coroner confirmed that she would be reopening the inquest into the man's death.
11. During that meeting, the police told the investigator that it had been suggested by the prisoner at his trial that he had warned the Prison Service that he was a risk to other prisoners. The investigator has carried out extensive searches of the prisoner's prison record, and I am grateful for the assistance of staff at HMP Liverpool which is where his record was at the time of this investigation.
12. Following the meeting the investigator returned to the prison to recommence the investigation. Over the next two days he carried out a number of formal and informal interviews with prison staff. The formal interviews were recorded and the transcripts of those interviews are attached to this report.
13. On 21 August 2009, the investigator met the Director and liaison officer to feed back his findings. The investigator told the Director he was likely to make a recommendation regarding the checking of back records. The Director accepted the finding and suggested it was probably an issue that should be raised nationally with NOMS.
14. Two months later, on 14 October the investigator returned to Bolton to meet with the Coroner and police. The purpose of the meeting was to update the Coroner on progress and give an indication on when the investigation report would be completed.

## **FOREST BANK**

15. HMP Forest Bank is a privately managed prison operated by Kalyx. It is situated on the outskirts of Salford. The prison opened in January 2000. The prison has a certified normal accommodation figure of 800, and an operational capacity of 1160 prisoners.

## **Her Majesty's Chief Inspector of Prisons**

16. Her Majesty's Chief Inspector of Prisons reports on all prison establishments. The majority of inspections are announced and allow the prison being inspected to prepare. However, a number of inspections are carried out without prior warning and are known as unannounced inspections.
17. In September 2007, the Chief Inspector of Prisons carried out a five day unannounced inspection of Forest Bank. In the introduction to her subsequent report she said that Forest Bank's first inspection in 2002 had been relatively positive. After a second inspection in 2005, the inspectors were not as positive and she said there were significant concerns about safety. However, in her 2007 report the Chief Inspector of Prisons said that safety had improved and overall the prison was not unsafe.

## **Independent Monitoring Board**

18. Each prison has an Independent Monitoring Board (IMB) and their role is to monitor the prison and to report any concerns that they have regarding how prisoners are treated. They feedback in the first instance to the Governor/Director, but may raise matters directly with the Secretary of State. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor/Director attending for part of the meeting. The Board produces an annual report to the Secretary of State for Justice.
19. In their latest annual report, covering the period December 2007-2008, the Forest Bank Board said: 'We draw to your attention that for a number of years the prison management have been attempting to obtain PNC facilities. The prison already has a dedicated Police Liaison Officer and it would greatly reduce the amount of time in dealing with all prisoner administration as well as being a useful intelligence tool. We would ask that this matter receives your urgent attention.'

## **Prison Service Orders (PSOs)**

20. Prison Service Orders contain long term, mandatory instructions, which are intended to last for an indefinite period. Any mandatory instructions to Governors/Directors are written in italics. Each PSO is given a title and unique reference number.

## **PSO 2750 Violence Reduction**

21. PSO 2750 is a document which introduces a strategic approach to the prevention of violence. It is constructed to enable each establishment to develop a local approach within existing resources.
22. The PSO includes a requirement for a cell sharing risk assessment (CSRA) which was initially introduced by the Prison Service in June 2002 and revised in 2005. Contained within PSO 2750 are four annexes:
  - A. On the safe side.
  - B. Cell sharing risk assessment. Risk of harm to others.
  - C. First Steps – Early Intervention.
  - D. Model procedure for informing staff of the issue of Prison Service Orders and instructions relating to the management of prisoners

For the purpose of this investigation, I concentrate on annex B. At section two and three of the CSRA form contained within this annex, the assessor is asked to indicate the level of risk the individual poses to others. There are three specific areas:

- Low. No current indication/evidence of risk, suitable for multi-cell location.
- Medium. No immediate risk, but situation will need to be reviewed regularly.
- High. Clear indication of high level of risk that prisoner might assault cell mate.

## **Police National Computer (PNC)**

23. Access to the PNC is allowed under an agreement between the Association of Chief Police Officers, the National Police Improvement Agency (NPIA) and NOMS. The NPIA is the agency responsible for running the system. The agreement for use of the PNC is to allow checks on previous convictions, which in turn are used to inform decisions for release on licence.
24. At the time of the man's death, the Prison Service was allowed direct access to the PNC in 46 prisons. Because not all prisons have a PNC terminal, NOMS had made arrangements for those with a terminal to share information with other prisons. Forest Bank accessed the PNC installed at HMP Hindley. HMP Drake Hall and HMP Askham Grange also used this terminal.
25. On 17 October 2008, after she had raised the issue with NOMS, the Chief Operating Officer wrote to my Deputy Ombudsman. In his letter he said there had been some problems with the use of PNC. He said these had led to the

NPIA imposing a moratorium on any further expansion of its use in the Prison Service, and, in particular, the installation of new terminals.

26. The Chief Operating Officer went on to say that NOMS had been working with the NPIA to develop a way forward and determine how PNC access could be improved. He said that, subject to effective audit and control mechanisms being in place, the moratorium on the installation of new PNC terminals would be lifted. Finally he said establishments wishing to pursue the installation of terminals should, in the first instance, contact the NOMS Security Group, adding that Forest Bank had done so and was trying to obtain a terminal.
27. At the time of issuing my draft report (November 2009) I understand approval has been given for a PNC terminal to be installed at Forest Bank. Although no date has been scheduled, I am told that it is expected to be before January 2010. In the meantime, the Director has trained two of his staff to use the equipment and they travel to Hindley as and when required to collect the data.

## KEY FINDINGS

### Prior to the man's reception into custody

28. On 29 September 2006, the prisoner was received into prison custody at HMP Risley. During the standard reception procedure, a Cell Sharing Risk Assessment (CSRA) was carried out. The member of staff completing the assessment deemed his risk as low.
29. Two months later, on 27 November 2006, the prisoner transferred from Risley to HMP Garth. In contrast to the previous risk assessment, the assessor at Garth raised the level of risk to high as he had assaulted another prisoner and set fire to a cell. The assessor also wrote, "Due to recent events, would not double this man [put him in a shared cell], although he stated he did not have a problem sharing."
30. The following year the prisoner moved from Garth to HMP Rye Hill. He arrived there on 15 March 2007. As at Garth, the assessor at Rye Hill deemed him as high risk. It was noted that the prisoner told the assessor that he would assault anyone else in his cell that night.
31. On 25 June, the prisoner transferred from Rye Hill to HMP Gartree. Unfortunately, despite extensive searches by prison staff the investigator has been unable to find any record of a CSRA being completed there. The investigator contacted Gartree and was told that they did not have a copy. However had the prisoner been regarded as medium or high risk, his name would have appeared in the prison risk register, which it did not. On that basis, the member of staff at Gartree suggested he was probably assessed as low risk.
32. Three days later the prisoner moved from Gartree to HMP Nottingham. Other than noting the number of prison moves, there is no reference on the CSRA to the concerns raised previously. The assessor on this occasion recorded the level of risk as low.
33. On 15 January 2008, the prisoner moved from Nottingham to HMP Forest Bank. At the time, Forest Bank was not carrying out the correct CSRA procedures or completing them.
34. The investigator discussed this issue with the Director. He said that, when he took over responsibility for the prison in 2008, he recognised that the prison was not complying with the correct CSRA procedures. Although there was a system in place, it was not the correct one and he gave instructions for the proper procedures to be introduced. He added that CSRAs were only completed for new arrivals, and not for prisoners already at Forest Bank. In March 2008, CSRA was introduced fully to the prison, but only for arriving prisoners. It was not backdated to include those already there.

35. On 19 February 2008, the man appeared at Stockport Magistrates' Court, having been charged with assault on a police officer and breach of conditional discharge. At court he was given a three month prison sentence, suspended for 12 months. As well as the prison sentence, he was given a supervision order and required to work unpaid in the community for 200 hours.
36. In the meantime, on 7 April, the man was released from Forest Bank under the terms of End of Custody Licence. However, he broke the conditions of the licence by committing further offences. On 3 July, the licence was revoked and he was returned to Forest Bank to continue his sentence.
37. On this occasion a CSRA was completed by a Senior Officer (SO) who recorded the level of risk as low. At interview the SO told the investigator that the prisoner had been taken to the prison by police officers. He said the only documents available to him at that time were the Prisoner Escort Record, the licence revocation and, as far as he could recall, a warrant detailing the further offences.
38. The SO said that, had the prisoner been transferred from another prison, his prison records would have accompanied him. He explained that, because this was not the case, he did not have access to the records. The investigator asked the SO whether it was possible to obtain the records of prisoners released and returned to prison. The SO said it was, but they would not have been available at the time when the CSRA was carried out. He added that the prison administration department would request the records from the last known establishment. The SO was unaware that the prisoner had been released from Forest Bank and that his records were still there.
39. The investigator asked the SO what he would have done had he known there was information to show that the prisoner had previously been assessed as high risk. The SO said he would have interviewed him in greater depth to determine why he had been considered as high risk. He added that, as he did not have the records and was unaware of the previous high risk, he had to take the information given by the prisoner at face value.
40. After making his own assessment, the SO passed the CSRA form to a nurse to add his comments and assessment. The nurse was also working in the reception area as part of the normal routine for receiving new prisoners. He agreed with the assessment carried out by the SO and assessed the prisoner as low risk.
41. After going through the reception procedure the prisoner was taken to a cell in the First Night Centre. The following day, he was moved to a cell in the detoxification unit.
42. In order to understand the procedure for obtaining prison records the investigator spoke informally to the Custody Clerk at Forest Bank. She said that, whenever a prisoner arrives, a temporary file is made up in reception. The Custody Clerk also said that, once it is known that another record exists, the old record is sent for and married up with the temporary file. She

confirmed that the prisoner's record was still held at Forest Bank. The investigator asked her whether, when the previous records do arrive, they were routinely checked for any information regarding CSRA or violence reduction. She said that, as far as she was aware, they were not.

43. The manager of B wing is also the prison safer custody lead with responsibility for CSRA. She told the investigator that all staff at Forest Bank required to complete CSRAs have received training in how to do so. The investigator asked the manager whether she is routinely notified when old records are received and of any previous information noted in other CSRAs. She said she was not, adding that it was a gap in the information system. She went on to say that it would be reasonable for her and her team to be told of previous CSRAs and to be given the opportunity to review their own assessments. The investigator also asked her what might have happened had such a system been in place and the high risk assessment noted at Rye Hill identified. She said a case review would have taken place and a new CSRA carried out. This could have led to the low risk assessment being raised to medium or high.

#### **The man's reception into custody**

44. Unfortunately, the man failed to comply with the court order imposed on 19 February and, on 20 August; he appeared again at Stockport Magistrates' Court. On this occasion, because he had breached the supervision order imposed in February, the suspended prison sentence was activated and he was taken to Forest Bank to begin serving his sentence.

45. When the man arrived at the prison he went through the normal routine for receiving prisoners. As part of that procedure, a CSRA was completed before staff allocated him a cell. The risk assessment was set as low, which meant there was no reason not to allocate him to share a cell with another prisoner. However, it was noted in section two of the CSRA that the man was concerned about sharing a cell, although there was no explanation why he was worried. After completing the assessment he was allocated to B wing, landing two, cell 13 (B2 13).

46. From what has been gleaned, it would appear that the man settled in well. He did not appear to be overwhelmed by his first experience of prison and gave staff no cause for concern.

47. Due to the length of the man's sentence, and providing he met the criteria for release under the End of Licence provisions, he was eligible for release on 15 September. On 27 August, in order to assess his suitability for the scheme, his previous conviction history, which was held on the Police National Computer, was requested from Hindley. (Unfortunately, there were delays obtaining the information and requests for information were not being dealt with as quickly as they should have been. I deal with this later in this report.)

48. In the meantime, the prisoner had completed the detoxification programme and preparations were made to move him to another wing to continue his

sentence. As there was nothing to suggest he should not be allocated to a shared cell, on 2 September he moved into the same cell as the man. The investigator has confirmed with the prison that there were no recorded problems between the man and the prisoner.

49. Five days later on 7 September, the man wrote a letter to his mother. In that letter he told her that he was to be released on 16 September, and asked that someone should collect him from the prison. He later spoke to his mother on the telephone and still believed he was to be released on that day. (It is not clear why he said the release date was 16 September.)

50. Under the impression that the man was being released, the man's mother went to the prison on 16 September to collect him. When she arrived, she was told by prison staff that he was not being released that day.

## **19 September**

51. I understand from police records that, at about 7.00am, prisoners were unlocked from their cells to collect their breakfasts. About 45 minutes later, two prison officers became aware of a disturbance outside the man's cell and went to investigate. When they arrived, they found the man lying on the floor unconscious, with a group of prisoners around him.

52. The officers raised the alarm and, once other prison staff arrived, all the prisoners in B wing were locked back into their cells. Prison medical staff arrived and, after assessing the man's condition, began resuscitation attempts. In the meantime, an ambulance had been requested. It arrived at 7.59am after which paramedics transferred him to Hope Hospital.

53. Having been told by police of the seriousness of the man's condition, I understand his family arrived at the hospital at about 12.40pm. There they met the prison chaplain. The man's family were with him when he was pronounced dead at 5.47pm.

54. The post mortem report noted the cause of death as a traumatic fatal sub arachnoid [brain] haemorrhage, bruising to left eye and temple, bruise above right ear and top of head, broken top vertebrae. It adds that the injury caused massive bleeding to the brain which resulted in death.

## **Following the man's death**

55. The man's mother told my investigator that the prison chaplain had acted as the prison's family liaison officer. She said he had contacted her a few times and had been helpful.

56. I understand from the mother that the Director arranged for flowers to be sent to the man's funeral and that prisoners held their own collection. She said the money collected has been distributed between the man's children.

57. The man's mother said she had been given the opportunity to meet a number of the prisoners. The man's mother and his brother also went to see the man's cell. They were accompanied by the prison chaplain and, after viewing the cell, they met the Director.
58. The man's mother said she had received money from the prison which had been held in the man's account, and also a number of letters. However, she added that his clothing was returned to his girlfriend, although she was not listed as next of kin. The investigator asked for an explanation, but at the time of completing this report, he has been unable to throw any light on why this happened. The Director may wish to make his own inquiries and to satisfy himself that staff understand the importance of ensuring that personal belongings should properly be returned to named next of kin.
59. An inquest into the man's death was held in October 2010. The jury were asked to provide answers to 15 questions, and found that the man had been unlawfully killed. The questions and answers provided were:

1) When the CSRA relating to the cell mate was carried out on the 3<sup>rd</sup> July 2008, was further information available which could have been taken into account?

*Yes, we believe further information was available.*

2) Would further information probably have caused that CSRA to have been completed differently?

*Yes*

3) If that CSRA had been conducted differently or completed differently, is it probable that the cell mate would initially have been allocated to a single cell?

*Yes, it is probable.*

4) On the basis of the information actually available, were reasonable conclusions probably reached by the staff completing that CSRA?

*Yes, we believe so*

5) In the light of any events after the CSRA of the 3<sup>rd</sup> July 2008, would it have been reasonable for staff to reassess the cell mate's suitability to share a cell?

*Yes, it would be reasonable to reassess.*

6) In the light of events after 3<sup>rd</sup> July 2008 was it reasonable or unreasonable for the cell mate and the man to continue to share a cell?

*In light of our findings to question 5, we consider it reasonable that a review of the cell mates CSRA would probably have impacted on whether cell sharing with the man should continue.*

7) Were the systems for managing and sharing information which might potentially have a bearing on cell sharing at HM Prison Forest Bank reasonable?

*We believe the systems to be inadequate at the time of the incident.*

8) Did the systems for managing and sharing information at HM Prison Forest Bank have any effect on the decision that the cell mate was suitable to share and continue to share a cell?

Yes

9) Were adequate attempts made to obtain and/or provide the PNC information record for the man?

*The request and provision were both inadequate.*

10) If the PNC information had been received before the 15<sup>th</sup> September 2008, would the man probably have been released on either the 15<sup>th</sup> or 16<sup>th</sup> September 2008.

Yes

11) Was the man unhappy about sharing a cell with the cell mate?

Yes

12) If so, did the man express any such unhappiness to staff at the prison?

*There was no evidence to that effect.*

13) Did the man have enough money to repay a debt of two packets of tobacco?

Yes

14) Is it likely that the man took a fan owned by the cell mate in order to repay a tobacco debt?

*We feel it is unlikely.*

15) Was the man unlawfully killed by another prisoner or prisoners?

Yes

## ISSUES

### Cell Sharing Risk Assessment for the man

60. On 20 August 2008, the man was taken to Forest Bank to begin his sentence. As part of that procedure, he was interviewed in the prison reception area and a cell sharing risk assessment was completed. This is normal procedure.
61. The officer completing section one and two of the document recorded his answers by way of a tick box. At section two, box nine and ten, the officer ticked the yes option. This indicated that he was concerned about sharing a cell (box nine) and that he said that he got angry or frustrated quickly (box ten). Unfortunately, there is little else recorded other than that the man preferred his own company. As a result, I do not know what he was worried about, or what efforts were made to find out.
62. The investigator discussed the assessment with the prison's safer custody lead. She said that all staff responsible for completing the CSRA forms at Forest Bank have received specific training in how to do so. She said that her expectation is that, after ticking the two boxes the man's risk assessment ought to have been at least medium. She was surprised in retrospect that the assessment was set at low. She said during her interview with the man:
- “In my view, I would have expected the officer to have investigated a little bit further in interview. The comment “just prefers own company” ... I would have expected perhaps at that point for it to be a medium, with further review on section 2 and section 4 as to how the prisoner presented.”
63. The prison safer custody lead added that all first and second sections are reviewed by a nurse, who then completes section three. She said that section four is then completed by the locating officer. She explained that this gives them the opportunity to disagree with the first assessment, or at least discuss the decision and rationale behind the risk level. On this occasion, the nurse and locating officer agreed with the officer's low risk assessment and the man was allocated to shared accommodation.
64. I understand that the NOMS is reviewing the CSRA procedure. In the meantime, whilst I make no formal recommendation, the Director may wish to consider whether there is a case for further training for his staff.

### Cell Sharing Risk Assessment for the prisoner

65. When a prisoner is released, their record is stored at their last prison for a minimum of six years. After this period, depending on the length of sentence, the record is either destroyed, or sent to a central store where it is kept for up to 99 years. However, if the released prisoner is later returned to prison, and providing the receiving prison knows that the prisoner has been in custody before, they can request the original records from the previous prison or the central store. (Stored records are often referred to as back records. I

recognise that obtaining back records can be time consuming and that it could be several days before the prison receives them.)

66. The prisoner arrived at Forest Bank on 3 July 2008 after his licence had been revoked. The reception officer carried out a cell sharing risk assessment unaware that his prison record was stored there. This meant the officer did not know of the high risk assessment completed at Rye Hill on 15 March 2007 or indeed any other assessments. At interview, the officer said that, had he known of the high risk assessment, he would have questioned the prisoner in greater detail about why he had previously been assessed as high.
67. Although I make no criticism of the officer, even if he had looked at the file I doubt whether he, or anyone else, would have looked back much further than the most recent assessment. In this case, that would have been the assessment carried out at Nottingham, which was low risk.
68. The investigator has tracked the prisoner's movements following his reception into Rye Hill. On 25 June 2007, he moved from Rye Hill to HMP Gartree where he stayed for two nights. I have been unable to establish why he remained there for such a short time. The prisoner then moved from Gartree to HMP Nottingham where he was assessed as low risk and remained there until 15 January 2008 when he was transferred to Forest Bank.
69. Whenever a prisoner moves establishment, the sending prison must ensure that an up to date CSRA accompanies the prisoner. If a CSRA is received, there is no expectation that the receiving prison should complete a further assessment. When this investigation was underway the prisoner was in HMP Liverpool. In an effort to clarify whether his risk remained high following his arrival at Rye Hill the investigator asked for the prisoner's file to be checked and copies of the CSRA forms to be sent to him. I am extremely grateful for the assistance of two members of staff at Liverpool, for their assistance. Unfortunately, despite extensive searches, they have been unable to find all of the CSRA documents covering the period in question. I am unable to explain why the record appears to be incomplete.
70. In the case of a prisoner assessed as medium or high risk, their details are recorded separately in a risk register and other violence reduction arrangements are put in place. The investigator contacted Gartree and was told that the prisoner did not appear in their register. Given that there is no information recorded in their risk register, I can only presume he was not considered to be medium or high risk at that time. I also presume that there was no repetition of the assault on another prisoner.
71. I have considered carefully the impact of the high risk assessment in 2007 and the officer's low risk assessment when the prisoner returned to Forest Bank. It is clear from prison records that, after he left Rye Hill in March 2007, he then went to three other prisons including Forest Bank where there appears to be no record of him being assessed as medium or high risk. On that basis I assume that he was assessed as high risk only at Rye Hill and did not cause concern at the other prisons.

72. That said, the circumstances surrounding the man's tragic death beg the question as to why information held in stored records is not considered, and what would be the outcome if it was. The investigator asked the prison's safer custody lead whether there was a system in place to ensure back records received from storage were routinely checked for CSRA assessment information. She said that there was not. The investigator asked whether, in her opinion, there was a gap in the procedures. She said that there was, adding that introducing such a system would trigger a review of the original assessment. I agree.
73. The investigator discussed the issue with the Director. He agreed that there was a gap, stressing that it should be looked at as a national issue rather than a local one. I make the following recommendation to NOMS:

**The National Offender Management Service should consider whether there is a need to issue guidance advising Governors and Directors that, once back records are received, previous CSRAs should be checked and the most recent assessment reviewed.**

### **Video monitoring**

74. Within the wings at Forest Bank there are a number of video cameras, linked to video monitors and recording equipment. The monitors are not under constant surveillance, but the recorded information is available to be played back as necessary.
75. I understand that when police officers tried to view the images following the fatal assault on the man they were unable to do so as the particular camera equipment was faulty. Although the investigator has been unable to determine exactly when the equipment was known to be faulty, it would appear to have been in that condition for some time.
76. It is my understanding from the police that, whilst the video evidence would have been useful in determining who went into the man's cell, it did not affect their enquiries. That said, there has to be a robust system in place to ensure any faults with such important equipment are properly logged and followed up.

**The Director of Forest Bank should ensure there is a proper auditable system in place to show when faults are reported and when they are repaired.**

### **Police National Computer**

77. At the time of writing this report, Forest Bank is still without a PNC terminal, although I understand it has been agreed that one will be supplied. In the meantime, the Director has arranged for checked documents to be collected from Hindley twice weekly. Additionally, he has arranged for two of his staff to be trained in the use of the terminal. I understand the situation has improved greatly since the man's death, and, since the publication of the draft report, I

have been informed that Hindley has put further management checks to ensure that there are no further issues surrounding PNC access there.

78. Given the circumstances described at paras 23-27 above, I do not think it would be useful for me to make a national recommendation to NOMS in respect of individual prisons' access to the PNC. It is self-evident that there would be practical benefits if all prisons had their own PNC terminals (and there is the separate issue of whether they should have the right to update the PNC as well as read from it). I simply note, therefore, that a joined-up criminal justice system is necessarily dependent upon joined-up Information Technology. I hope and trust that all prisons will soon enjoy their own terminals to access the PNC.

### **Family meeting**

79. The man's mother told the investigator that her son was a good achiever at school and a keen sportsman. She added that he was always laughing and liked to play jokes. The mother said her son was a hard worker and, as well as being a good brother, he was very popular.

80. The man's family asked a number of questions of my investigator that I hope I have answered earlier in my report. During their meeting the man's mother said her son had told them he was unhappy about sharing a cell with the prisoner. She said he told them he was having difficulty sleeping and that the prisoner was smoking drugs. The man's mother asked whether the man had ever asked to move to a different cell. The investigator has been unable to find any evidence to suggest that the man had ever asked to move to a different cell, or told prison staff he was unhappy sharing a cell with the prisoner.

81. His mother also asked what rules existed regarding prisoners smoking in prison. In general, prisoners are allowed to smoke in designated areas only (including their cells). Unless there are operational reasons that makes this impossible, non-smokers should not be expected to share with those who do smoke.

82. The man's brother asked whether the wing staffing levels were correct and whether the officers were trained. I understand the staffing levels were correct. All prison officers must undergo specific training on entering the Prison Service.

## CONCLUSION

83. It is clear that had the proper systems been in place to ensure that the PNC checks were carried out efficiently, the man would have been released on End of Custody Licence on 15 September 2007 and almost certainly still alive today. For the reasons I have given above, I do not think it would be useful for me to make a national recommendation to NOMS in respect of individual prisons' access to the PNC. However, it is self-evident that there would be practical benefits if all prisons had their own PNC terminals. I have been pleased to learn that Forest Bank will be receiving a PNC terminal early in 2010.
84. I have considered the cell sharing risk assessment relating to the prisoner. Although there is evidence to show that he had previously been regarded as high risk, the risk was later reduced to low, with no further instances where the risk was any greater. Additionally, the information from Forest Bank is that, from the time when the prisoner moved into the same cell as the man, there were no recorded problems between the two of them. Notwithstanding what the man's mother has reported (above, para 79), this would suggest that both men were content to share a cell.
85. As well as the risk assessments I have considered whether the man was someone who ought to be considered as vulnerable. Again I can find no evidence to suggest that he should have been; in fact, the opposite appears to be true in that he settled into prison life well. I conclude, therefore, that the fatal attack upon him could not reasonably have been predicted.

## **RECOMMENDATIONS**

1. The National Offender Management Service should consider whether there is a need to issue guidance advising Governors and Directors that, once back records are received, previous CSRAs should be checked and the most recent assessment reviewed.
2. The Director of Forest Bank should ensure there is a proper auditable system in place to show when faults are reported and when they are repaired.