

**Investigation into the circumstances surrounding the  
death of a man at HMP Whatton in August 2008**

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

**October 2013**

This is the report of an investigation into the death of a man at HMP Whatton in August 2008. His cellmate has since been convicted of his murder. On the night of the incident he called staff to the cell he shared with the man at about 12.30am. Nearly 25 minutes later, once staff had removed him from the cell, they checked the man's vital signs and found none. Nevertheless, resuscitation was attempted until he was pronounced dead at 1.35am.

Regrettably the investigation has been delayed primarily because of the criminal prosecution and conviction of the man, and his subsequent appeal. Further matters were raised with the Crown Prosecution Service, which prevented my office from pursuing enquiries until last year. I am sincerely sorry for the delay in investigating the serious circumstances of his death and for the distress this must have caused his family.

The investigation examines whether it was reasonable for someone with the cellmate's custodial history and index offence to be sharing a cell. He had been convicted of raping a man and was accused of serious sexual assault against other prisoners on two occasions while he was in custody. Neither accusation resulted in a criminal charge.

The investigation found systemic failures in the risk assessment processes which suggest this death should have been preventable. Although key security information was eventually transferred with the cellmate as he moved between prisons, it was not always acted on promptly or properly considered. Some of it should have rung alarm bells about whether he was in the appropriate security category. Important information about his risk when he transferred from Manchester prison to Wymott seems not to have accompanied him or was lost. Poor communication of relevant risk information between and within prisons he was held in is a recurrent theme and decisions about his risk were taken without reference to structured risk assessments within the offender management system.

Cell sharing risk assessment procedures have improved and strengthened since the man's death, but like all such guidance it is only as good as it is applied on the ground and requires careful consideration of all the relevant information.

Finally, the report considers the actions of staff on the night of the incident to determine whether they struck the appropriate balance between security and the preservation of life.

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

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**Prisons and Probation Ombudsman**

**October 2013**

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## SUMMARY

1. The man was murdered by his cell mate in August 2008. The pair had shared a cell for less than a week. Neither was regarded by the prison as a particular risk to other prisoners at the time of the murder.
2. The man was serving an indeterminate sentence for public protection, with a minimum tariff of three and a half years. He had spent more than three years at HMP and YOI Doncaster, where there were no appropriate courses for him to address his offending behaviour and demonstrate he was suitable for release. He was eventually transferred to HMP Whatton in July 2008 and was on the waiting list for the Sex Offender Treatment Programme at the time of his death.
3. The cellmate began his period of imprisonment at HMP Manchester. As soon as HMP Manchester discovered that he was charged with the rape of an adult male, his cell sharing risk assessment (CSRA) was reviewed to recognise that he posed a high risk to other prisoners. He remained high risk for the duration of his time at Manchester. Security information indicated that he had been reported to the police on two separate occasions, following allegations of serious sexual assaults of fellow prisoners. After a year and a half of deliberation by the police and the Crown Prosecution Service (CPS), there was found to be too little evidence to proceed to charge for the first allegation. There was no record of the second matter being referred to the police, apart from some observations by prison staff on his records. Adjudications were not completed for either alleged attacks but both incidents were recorded in his security file.
4. Convicted of rape, the cellmate was assessed as a medium risk security Category C prisoner offender, following the strict algorithm of categorisation used in the prison service which did not take into account the security information about the alleged sexual assaults. He was transferred to HMP Wymott, a Category C prison, to complete the Sex Offender Treatment Programme (SOTP).
5. On arrival at Wymott the cellmate was assessed as "low/medium" risk to other prisoners for cell sharing despite having been identified as a high risk at Manchester. There is no evidence to explain why his risk had altered with his transfer. He remained at Wymott for six months, but did not complete the sex offender treatment programme because concerns about his risk meant he was not held on the vulnerable prisoners unit. His security file also logged allegations that he was grooming new prisoners on the induction wing, at Wymott. (The VPU is mainly used to accommodate prisoners with a sexual offending history.) He and his legal representatives corresponded with the prison to request he attend the sex offender treatment programme but he transferred from Wymott in December 2007 to Whatton without doing so.
6. The cellmate was assessed as at medium/low risk to other prisoners when he first arrived at Whatton. For the first month he shared cells and a dormitory with other prisoners without incident. Security information including the

allegations of sexually assaulting other prisoners was received and discussed at a risk management meeting in December 2007 but no action was taken. The security information was discussed again at a similar meeting in January 2008 and this time his CSRA assessment was changed to high risk to reflect the danger he posed to other prisoners. The CSRA was subject to regular reviews, in line with the prison's policy, and by February 2008, staff felt that his risk had reduced and he was assessed as a medium risk to others. This judgement was revisited monthly and, even taking the allegations into account, his risk to others when sharing a cell remained assessed as medium until June 2008, when it was reduced to low.

7. The cellmate was made subject to Violence Reduction Strategy (VRS) monitoring on three occasions at Whatton and was subject to such monitoring when he murdered the man. On the first two occasions, his cell sharing risk assessment was reviewed and his risk level was considered appropriate. The last Violence Reduction Strategy document was opened in the week before the man's death and no cell sharing risk review was completed, in apparent contravention of the national guidance which required a re-assessment if there is a significant event that triggers concern.
8. The cellmate started the SOTP course in May 2008, and was said to have struggled to adapt to the challenges of the course. SOTP facilitators did not know about the information on his security file, nor were they aware that he was subject to VRS monitoring. There was some communication between facilitators and wing staff as his attendance was erratic and the two areas worked together to enforce a compact designed to improve his compliance with the SOTP.
9. In July, the cellmate approached officers and volunteered to share a cell. Officers agreed with the Principal Officer managing the wing that "it would be inappropriate in view of recent [allegations] and this current VRS document" but his CSRA was not reviewed. Two weeks later, after the VRS document had been closed, he moved into a dormitory cell, shared with two other prisoners. On 16 August, he was moved to the cell he was to share with the man. The man moved into the cell on 22 August 2008.
10. According to prisoners' accounts, the cellmate indicated to other prisoners on the wing on the afternoon of 22 August that he intended to have sex with his cellmate 'no mater what'. None of the prisoners suggested that staff were aware of these remarks and there were no security incident reports about this until after the man's death.
11. On the night of the incident the cellmate rang his cell bell and told the Operational Support Grade (OSG) on night duty that he needed to speak to the Night Orderly Officer. The OSG contacted the manager. He rang his cell bell again and told the OSG that he thought he had killed his cellmate. Another OSG contacted the Orderly Officer and asked for her urgent attendance. Staff could not clearly see the man in the cell. Twenty one minutes elapsed between the time he told the OSG that he had killed the man and the cell door being opened. Once the cell door was opened and he was searched and removed to

another cell, a further three minutes elapsed before the man was seen. An ambulance was not called until staff had assessed his condition.

12. Since the man's death there has been a significant change in the CSRA process but there is little doubt that the way the CSRA procedures in place at that time were implemented did not adequately protect other prisoners from the risk the cellmate presented. Had the processes operated in the way they were intended the man's death should have been preventable. The precautions taken to ensure the safety of the prison on the night when he was killed were not effectively balanced against the possibility of preserving him and he ought to have been attended to earlier by staff.
13. The investigation was suspended for the ongoing criminal investigation by the police and subsequent appeal and it was not until August 2011 that the coroner gave the go ahead for the investigation to proceed.

## THE INVESTIGATION PROCESS

14. A senior investigator was originally appointed to lead the investigation into the man's death. She visited Whatton on 27 August 2008 and met staff, the Governor and reviewed the man's and the cellmate's records.
15. The Prisons and Probation Ombudsman is obliged to investigate all deaths in custody, but investigations must not compromise any ongoing criminal matters. The investigator met Nottinghamshire police and the Coroner in the month after the man's death and was asked to suspend the investigation until the resolution of criminal matters.
16. A family liaison officer was appointed and contacted the man's family at the beginning of the investigation to explain the process. She also explained that our investigation was suspended so as not to compromise the criminal investigation ongoing at the time.
17. The cellmate was convicted of murder and sentenced to life in prison in May 2009. He unsuccessfully appealed his conviction. Throughout this time the investigation team kept in touch with Nottinghamshire police. The police provided documents and statements gathered during the course of their criminal investigation. In May 2010, the investigator's colleague took over the investigation from her and met Nottinghamshire police. They agreed that she should proceed with the Ombudsman's investigation, in liaison with the police and the Coroner, although requested that she concentrate her enquiries at Manchester and Wymott until further notice because the police were conducting further enquiries at Whatton.
18. The family liaison officer wrote to the man's family to explain that our investigation had started again. The family replied through their solicitor, listing concerns that they wanted to be considered as part of the investigation.
19. After reviewing the paperwork, the investigator met the police again and visited Whatton for two days with a senior investigator. The team interviewed staff and spoke to the Governor, the Independent Monitoring Board (IMB) and the Prison Officers' Association. Both investigators were shown around the induction unit, looked around the prison, and visited the cell where the man was murdered.
20. Following the visit to Whatton, both investigators went to HMP Woodhill where the cellmate was now held to review his security file. The team spoke to the police liaison officer there and the security department to clarify details of outstanding allegations against him from his time at Manchester prison at the beginning of his sentence.
21. In October 2010, the investigator went to HMP Manchester to conduct four interviews about the cellmate's categorisation and security information. She reviewed his core records and tried to establish the conditions of his transfer between Manchester and Wymott. Later that month, she visited Wymott to interview four members of staff about his cell sharing risk assessments,

participation in the sex offender treatment programme and categorisation. She also established how security information is used in the prison.

22. The family liaison officer and the investigator visited the man's family in January 2011 to explain the progress of the investigation to date and what the next steps were.
23. Later in January 2011 the investigator met the Coroner and the Deputy Coroner, who was leading the inquiry into the man's death on her behalf, and the police acting on behalf of the Coroner. They updated each other on the respective progress of their investigations and the investigator agreed to share her provisional findings to date with the Coroner and police to assist their enquiries.
24. In May 2011, the investigator arranged to visit West Bridgford Homicide Unit. She met HM Deputy Coroner and the police and viewed the Closed Circuit Television footage (CCTV) of the afternoon before the man died and the night he was discovered in his cell. At that stage she was also given copies of all of the statements taken by police and a log of the evidence the police had gathered as part of their investigation.
25. In March 2011, in a letter to the police leading the investigation on behalf of the Coroner, the investigator explained the progress of her investigation to date and what steps she needed to conclude the investigation. Although there was no formal correspondence to allow her to conclude the investigation, in August 2011 she was told by the Deputy Coroner that the police enquiries were drawing to a conclusion and she could now proceed.
26. The investigator returned to HMP Whatton in September 2011 and interviewed ten members of staff. She also spoke to a representative of the POA and the IMB to update them on the investigation. She fed back her preliminary findings to the Governor for her consideration during her visit and followed this up in writing.
27. It is usual in the Ombudsman's fatal incident investigation for a clinical review to be commissioned by the local Primary Care Trust (PCT) to examine the clinical care that the deceased received in custody. In this case, the clinical care that the man received while in prison is unrelated to the cause of his death. The PCT agreed to review the care that the cellmate received, especially in relation to his mental health, but he withheld his permission to consider his clinical records and there is therefore no clinical review in this case.
28. The man's family asked the investigator to explore the following areas as part of the investigation:
  - Would the Ombudsman be able to interview people that had already been interviewed by the police?

*The investigator had access to comprehensive police statements. Nevertheless, she was also able to interview people that had been*

*interviewed by the police to address some issues that the police had not pursued, as they were not relevant to the police investigation.*

- Could the investigation set out how staff were first called to the man's cell on the night of the incident?

*The investigator describes the response to the cell bell in the investigation report. She subsequently considers the appropriateness of the response.*

- Will the investigator have access to the transcripts of evidence given by prisoners who were part of the cellmate's criminal proceedings, for consideration in the investigation?

*The investigator requested copies of the transcripts to consider but the cost of obtaining the transcripts was prohibitive but we have seen the prisoners' statements to the police.*

- Can the investigator confirm whether there was any population pressure that resulted in prisoners having to share cells at the time that the man moved into the cell?

*It was not possible to establish the exact population pressures at Whatton at the time of his death so long after the event and whether these directly contributed to cell sharing but all sharing of cells originally designed for one are as a result of general population pressures in the prison estate. The investigator explores fully the reason that the cellmate was allowed to share a cell. There is little to suggest that this was associated with shortage of spaces.*

- Would the investigator have access to the cellmate's medical record as part of the investigation process?

*His medical record is a confidential document and even as a convicted murderer the law requires his consent before it could be considered as part of the investigation. Regrettably, he did not give his consent for his medical record to be used in this way.*

- Were the cellmate's or the man's telephone calls monitored? If so, would they be considered as part of the investigation process?

*As with all prisons, telephone calls at Whatton are recorded automatically under the PIN phone system but only a proportion are monitored on a random basis unless there are specific grounds for suspicion. Legally privileged and other confidential calls are not recorded. The investigator did not have access to transcripts of their telephone conversations.*

- Can the man's movements be confirmed for the afternoon of the day of the incident, particularly whether he was playing pool at that time?

*As part of their investigation, the police gathered CCTV footage of the landing outside the man's cell from 12.43pm on the afternoon of the day of the incident. The pool table was not covered by the CCTV footage. The police arranged for the investigator to review all of the CCTV footage available, and she has set out the movements.*

The family responded to the findings of the investigation. They raised a number of concerns, and the final report has been amended to reflect the inaccuracies identified. While some concerns did not result in changes to the report, we have addressed them in separate correspondence.

## **HMP WHATTON**

29. HMP Whatton is a Category C prison that accommodates adult male prisoners convicted of sexual offences. The prison expanded considerably in 2006 and holds over 800 prisoners mainly in single cells. Prisoners transferring to Whatton are expected not to be in denial of their offence or maintaining their innocence, so that they are ready to address their offending behaviour.

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

30. The last announced inspection of Whatton was in January 2007, before either the cellmate or the man arrived at the prison. There was a full unannounced inspection in March 2010, a year and a half after the man's death.
31. At the time of the announced inspection in 2007, the Inspectorate reported that Whatton was still adjusting to almost doubling its capacity and despite a rapid period of change", concluded that Whatton was "a reasonably safe prison" although there was concern that the comprehensive violence reduction policy was not being used by staff. No one had been trained in the requirements of managing violence reduction and there were a significant number of new officers that did not feel confident about how best to challenge inappropriate behaviour.
32. In 2010, the Inspectorate also found that Whatton was a "reasonably safe" prison that had made "commendable progress". However, some incidents of bullying were not being reported to the offender management unit or the psychology team, a matter which will be considered in relation to the cellmate's time at Whatton

### **B wing**

33. The man and the cellmate shared a cell on B wing at the time of the murder. This is the oldest part of the prison and the central staff office is on the ground floor, although each landing has its own office. B wing is also where the majority of offending behaviour programmes take place and most of the population walk through the wing on weekdays. In 2006, B wing was identified as a fire hazard with significant health and safety concerns for the prisoners accommodated there. Since then a significant refurbishment programme has updated the wing although the 2010 inspection noted that there were still problems with the plumbing system and a lack of privacy screens for showers and toilets.
34. The Inspectorate noticed "positive examples of staff-prisoner relationships" in 2007, although reported that "this was not universal and more formal interactions were the norm". In the later, unannounced inspection, staff-prisoner relationships were described as "reasonable" across the prison, but better on B wing.

## **The Independent Monitoring Board (IMB)**

35. The Independent Monitoring Board (IMB) is made up of volunteers from the community who visit the prison frequently to monitor fairness and respect for people in custody, and ensure that proper standards of care and decency are maintained. The IMB produce an annual report for the Justice Secretary, which is published on their website, with recommendations for improvements.
36. The investigator met the Chair of the IMB and his team on several occasions throughout the investigation process. They provided a copy of correspondence with the then Justice Secretary outlining their concern about cell sharing with a population of prisoners with a history of sexual offending. The Chair was worried that the continued use of shared cells constituted a breach of the duty of care to prisoners, as the risk they may present to one another cannot be effectively managed.
37. The Chair showed a response he received from a copy recipient, then the Shadow Justice Secretary. (He has since assumed the role of Justice Secretary substantively.) At the time the Shadow Justice Secretary shared the IMB's concern about the practice of sex offenders sharing cells and suggested that an inquiry into this matter was warranted. The Justice Secretary did not share the IMB's concerns that cell sharing was inappropriate for sex offenders and did not propose an inquiry. No further correspondence has been exchanged relating to this matter.

## **HMP & YOI Doncaster**

38. HMP and YOI Doncaster is a local Category B prison which accommodates up to 1,145 male prisoners. The man was at Doncaster from August 2005 where he was held when he received his indeterminate sentence. At an inspection in 2008 the inspectorate noted that 'As at other local prisons, we found a number of indeterminate sentenced prisoners who had not been moved on quickly enough to appropriate training prisons where they could address their risks'. The Inspectorate noted that this was a national problem. The sex offender treatment programme was not offered at Doncaster and he waited until July 2008 to transfer from Doncaster to Whatton to complete the programme.

## **HMP Manchester**

39. HMP Manchester holds nearly 1,300 prisoners. It serves local courts, but also has a high security unit for prisoners who have been assessed as the most likely to escape and pose a high risk to the public. The cellmate served previous sentences at Manchester. It was while he was serving a different sentence at Manchester for driving offences in December 2006, that he was charged and subsequently convicted of the sexual offence that brought him to Whatton a year and a half later.
40. It was at Manchester that the cellmate was assessed as being a Category C prisoner, and he was transferred from Manchester to Wymott to complete the sex offender treatment programme.

## **HMP Wymott**

41. HMP Wymott is a Category C prison near Preston, which accommodates 1,144 prisoners. The prison is comprised of two parts: one side of the prison accommodates only sex offenders and the other side of the prison is described as 'integrated', which means that it accommodates sex offenders and prisoners with other types of offence together. When the cellmate arrived at Wymott in June 2007, he was accommodated on the integrated side of the prison, where he remained until he was transferred to Whatton six months later.

## GLOSSARY

### Cell Sharing Risk Assessments (CSRA)

42. A Cell Sharing Risk Assessment (CSRA) is a form used by prison staff to assess the suitability of individual prisoners to share a cell with another prisoner. It should be completed each time a prisoner arrives at a new establishment, as soon as possible after arrival.
43. At the time of the man's death, instructions about the CSRA were set out in Prison Service Order (PSO – a national instruction for prisons) 2750 - Violence Reduction. The purpose of the cell sharing risk assessment tool was described in the PSO was to:
- “draw together information about risk
  - make best use of documentary evidence;
  - support staff judgement about allocation to cells and risk management;
  - record additional operational precautionary measures for a prisoner identified as a potential risk, where cell sharing is unavoidable;
  - provide a record about risk of harm to others as a prisoner moves between wings/prisons, or needs peer support;
  - to enable early identification of racist, homophobic, or violent prisoners;
  - to ensure that other Prison Service procedures to protect potential victims are followed.”
44. In April 2011, Prison Service Instruction amended the original order and replaced it with a new system outlined in PSI 09/2011 - The cell sharing risk assessment. The new instruction is aimed at improving the CSRA process, by ensuring that “an evidence based check of specified sources is carried out on the day prisoners are received into custody, or the next working day”.

### Categorisation

45. There are four categories for sentenced prisoners: A, B, C and D, with category A prisoners requiring the highest level of security and category D prisoners the lowest level of security. The category is determined by the likelihood that the prisoner will try to escape and the risk that they pose should they do so. Previous custodial behaviour can be taken into account, if a prisoner requires a higher security prison to address the risk they pose to control.
46. The man and his cellmate were both Category C prisoners at the time of the man's death. According to PSO 0900 – Categorisation and Allocation, Category C prisoners are “Prisoners who cannot be trusted in open conditions, but do not have the resources and will to make a determined escape attempt”.

### **Indeterminate Sentences for Public Protection (IPPs)**

47. Indeterminate sentences for public protection set a minimum period to be served before a prisoner can be considered for release. After this the prisoner must satisfy the Parole Board that he is no longer a risk to the public before he can be released.

### **Assessment, Care in Custody and Teamwork (ACCT)**

48. Assessment, Care in Custody and Teamwork (known as ACCT) is the principal tool for assessing, monitoring and managing any prisoner thought to present a risk of self-harm or suicide.

### **Sex Offender Treatment Programme (SOTP)**

49. Sex offenders are usually expected to complete the sex offender treatment programme (SOTP) as part of their sentence plan. The programme aims to give prisoners insight into their behaviour and the means to prevent them from re-offending in the future.
50. There are three main types of sex offender treatment programmes, core, adapted or rolling. Most prisoners will undertake the core programme, if prisoners are in need of extra learning support they will attend the adapted programme and the less structured rolling programme is usually used for lower risk prisoners.

### **Person Escort Record (PER)**

51. A Person Escort Record (PER) is a form that accompanies prisoners on all journeys from and between prisons. It is a means to share information between prisons and escorting agencies about a prisoner's risks and custodial history. It includes information about a prisoner's risk to themselves and others. Until May 2009 the PER was known as the prisoner escort record.

### **The Incentive and Earned Privileges Scheme (IEPS)**

52. The Incentive and Earned Privileges Scheme (IEPS) is designed to encourage prisoners to progress through their sentence plan, to undertake work or other purposeful activity and create a better and safer environment for prisoners and staff. There are three levels under IEPS – basic, standard and enhanced – with all new prisoners initially being on standard level. Changes to that level will then depend on their conduct and progress through their sentence plan.

## KEY EVENTS

### The man's time in HMP and YOI Doncaster

53. The man was released on licence from HMP Acklington in December 2004 after serving six months for indecent assault. Eight months later, he was accused of further sexual offences and he was recalled to custody on 15 August 2005. On arrival at Doncaster, he was assessed as a low risk to share a cell with another prisoner, although he told staff that he had concerns about sharing a cell.
54. In line with national policy, the man received a notice explaining his right to appeal his recall, although he waived this right. He was identified as a potential life sentence prisoner on 16 August and given information about the indeterminate sentence for public protection (IPP).
55. On 5 September, the man was convicted of two counts of sexual assault of a female minor. Two days later, he was sentenced to an IPP with a minimum tariff of three years. The probation officer who completed his pre-sentence report noted his dangerousness and the likelihood of his re-offending and suggested he needed to attend the sex offender treatment programme while serving the custodial part of your sentence". At the time all prisoners with an IPP sentence were initially categorised as security category B – for whom high security conditions are not necessary, but escape needs to be made very difficult.
56. The man settled into life at Doncaster. He became the prisoner representative for IPP sentenced prisoners and worked as a cleaner, a trusted position. Due to continued excellent behaviour, he gained enhanced status on the Incentives and Earned Privilege (IEP) Scheme and gained additional privileges such as more visits and a higher allowance of private cash.
57. The man's first annual sentence review took place on 21 August 2006. He was recorded as "very polite and helpful to staff". He continued as a wing cleaner and undertook courses, although the sex offender treatment programme, central to his sentence plan, was not available at Doncaster. His next annual review took place on 6 September 2007, when his behaviour was described as "very good". However, he could not progress until he had completed the sex offender treatment programme, because he was still considered at risk of reoffending.
58. On 7 February 2008, the Prison Service issued a national instruction concerning prisoners who were sentenced to an IPP, with a tariff of three years or less. Due to an unexpected level in the use of the IPP sentence, access to courses had prevented many prisoners from progressing their sentence and being released on tariff. The instruction required that all IPP prisoners with a tariff of three years or under should be considered for re-categorisation to Category C, and transferred to corresponding prisons to complete offending behaviour work.

59. Following this instruction, the man was re-categorised as Category C on 20 February 2008. In a sentence planning and review report completed on 18 March, the lifer manager at Doncaster reflected his exemplary behaviour in custody:

“I can report that he has acted as the Indeterminate Sentences representative for his wing since the scheme began in March 2007, and he has always carried out his duties diligently.”

60. In the review board meeting, the man made his frustration about his lack of progress known, “he is willing to undertake the work and is unhappy that the system has held him back”. While being assessed by a psychologist for a progress report, he told the psychologist that he understood he would not be considered for parole “as he believed he would be required to attend a sex offender treatment programme”.
61. On 2 May 2008, at a sentence plan review meeting held at Whatton (although the man had not yet transferred from Doncaster) it was noted that a transfer could be facilitated, but the parole board were still awaiting his ‘parole dossier’ (various assessments and documents from professionals for consideration for parole) before he could transfer. After correspondence over the next month and a half between offender supervisors in prison and his community offender manager (probation officer) a Parole Assessment report was carried out. He said he broadly agreed with the assessment, requiring him to do further offending behaviour work, specifically the sex offender treatment programme. The parole dossier was sent to the parole board on 2 July and he was eventually transferred to Whatton on 17 July 2008, nearly three years after receiving his indeterminate sentence, and less than a month before his minimum tariff was due to expire.

### **The man’s time at HMP Whatton**

62. The man’s Prisoner Escort Record (PER) detailed that he was assessed as a risk to children and that he was vulnerable (this may have referred to the nature of his offence, although there is no explanation on the PER). An officer carried out his cell sharing risk assessment in the reception area of the prison. He noted that he was a smoker and he had been an enhanced prisoner. He told the officer that “he can get frustrated but is ok to share”. The officer assessed that he was a low risk to other prisoners and could therefore share a cell.
63. The man remained on the first night centre and underwent the induction programme, which he completed on 24 July. On 1 August, he met his offender supervisor, who followed the meeting up with an email to confirm their discussion with relevant prison departments. She acknowledged that he had “been unable to complete any offence focussed work due to the lack of programmes at Doncaster despite being very motivated” and that the delay in his parole dossier being prepared “set him back even further”.
64. According to the risk assessment completed by the psychologist for his parole dossier, the man had been assessed as “medium risk for sexual recidivism

[repeat offending], he is also a medium risk for violent offending giving him a combined risk rating of medium". Once his offender supervisor had outlined his risk assessment, she concluded that he would be put on the waiting list for the sex offender treatment programme, but he would be unlikely to begin the core programme until October 2008.

65. In line with national policy, the man's cell sharing risk assessment was reviewed after three weeks, on 5 August. Nothing had altered staff's perception that he posed a low risk to other prisoners and another officer confirmed the earlier assessment.
66. On 12 August, the man's minimum tariff expired. He moved wings on 18 August, and was then asked if he would mind moving to share a cell with another prisoner. Although he preferred not to share a cell, he agreed to move to a double cell to co-operate with the officer's request.

### **The cellmate's custodial history**

67. The cellmate was convicted of driving offences, theft and criminal offences on 20 February 2006. Just after receiving his sentence, he told the judge that he wanted to kill himself and suicide prevention measures were opened. He was taken to HMP Manchester to await sentencing. When he arrived at Manchester, he asked for protection because on previous sentence he had received threats because he was gay.

### **The cellmate's time at HMP Manchester**

68. Less than two weeks after arriving at Manchester, an officer wrote about "an alleged incident on a previous sentence", involving a "sexual attack in the showers" in the cellmate's ongoing suicide prevention record. The source of that information is not clear from the records and neither is when the attack took place or whether he was the alleged victim or attacker. Nevertheless, the officer recorded, "it would be advisable to allow him time to shower when no other prisoners in the vicinity".
69. On 8 March, the cellmate was escorted to a police station where he was charged with rape of an adult man in the community. The offence was alleged to have taken place in the short time between his release from his previous sentence at Manchester in December 2005 and his current sentence. When he returned to the prison, he was assessed as high risk to share a cell as a result of the new charge and was located in a single cell. Less than a week later, on 14 March, he received a 20 week sentence for criminal damage, driving offences and theft.
70. The cellmate's first security categorisation form was completed on 15 March. Due to the nature of the offences of which he was convicted, he was assessed as a category C prisoner. However, as there was an outstanding charge of rape by this time, he remained in Manchester, a category B local prison, as an uncategorised prisoner.

71. The cellmate settled into the unit and the suicide prevention measures opened at court were closed on 27 March. Four days later, another prisoner alleged that he had carried out a serious sexual assault on him when they were in prison together in December 2005 (this is possibly the incident referred to by the officer earlier that month). A Senior Officer (SO) recorded the allegation in his wing history and reported it to the police. The SO carried out a cell sharing risk review and concluded that he was to remain high risk and should be located in a single cell. He noted on the cell sharing risk review that “the cellmate totally denies any allegation of a serious sexual assault”.
72. The next day, on 2 April, a governor spoke to the cellmate and they agreed that he should not go into other prisoners’ cells or have any prisoner in his own cell while the rape charge was outstanding. According to his security record, he was adjudicated the following day for seriously sexually assaulting a prisoner between 9 December and 30 December 2005. The security record is likely to be referring to the opening of an adjudication, but there is no record of the eventual outcome.
73. The cellmate was reported to respond badly to “the prospect of a second rape charge”, and another Assessment Care in Custody and Teamwork (ACCT) document was opened to monitor the risk he presented to himself. His risk to other prisoners was still assessed as high and therefore he was not able to share a cell as part of his support plan. (In PSO 2700 – suicide and self-harm management, cell sharing is recognised as a way of reducing loneliness and giving an at-risk prisoner someone to talk to.)
74. Over the next month, the cellmate wrote to a friend in another prison. His letters were intercepted because they contained inappropriately threatening remarks, directed primarily at another prisoner, for example:

“How dare he call me a rapist when he’s been done for fiddling with little girls. HE WILL DIE.”
75. In other letters written at the same time, the cellmate described his frustration at being described as a bully, and his difficulty in dealing with anger without resorting to violent thoughts. In one such letter, he wrote about his plans to murder people when he was released. A note was made in his ACCT ongoing record and his security file was updated.
76. The cellmate was due to appear at Crown Court but his warrant was not forwarded by the magistrates’ court in time and he was released for one day. When he was brought back into custody on 29 April on remand for the rape charge officers recorded that he had to be kept separate from three prisoners. He was to be kept separate from the prisoner who he was alleged to have sexually assaulted, the prisoner who he wrote about threateningly and a further prisoner who is not mentioned elsewhere on the files reviewed by the investigation team, so the reason for not allowing contact is unknown.
77. The cellmate was still assessed as at risk of harming himself and an ACCT document was opened. On 12 June 2006, he asked to speak to a mental

health nurse. According to the ACCT document, he told a Registered Mental Health Nurse (RMN) that he was “experiencing constant thoughts/urges to cut a male’s throat”, particularly another nurse at the prison. He said that he felt “sexually excited” at the thought and went into detail, “showing no empathy with the intended victim”. Ten days after this interview, he was assessed by a psychiatrist, who determined that he should be referred to a Personality Disorder Unit. Otherwise, the psychiatrist found that he was fit to be located on a residential unit (rather than in the healthcare centre) and was suitable to share a cell “from a psychiatric point of view”. (There is no further mention of the referral in the records reviewed by the investigation team and as explained, unfortunately we did not have the right of access to his medical records.)

78. The cellmate remained a high risk on his cell sharing risk assessment and stayed in a single cell throughout the summer of 2006. On routine cell sharing risk reviews in September and October, it was noted that he “tended to be friendly with vulnerable prisoners”. Despite his high risk, no risk minimisation plan was completed as was required. In October, he alleged that a prisoner had sexually assaulted him on a number of different occasions and asked for that prisoner to be moved. Less than a week later, he was moved wings and became the cleaner, a responsible job reserved for prisoners who have built trust with staff through good behaviour. It enabled him to move around the prison with less supervision. His ACCT document was closed because he was no longer considered at risk of harming himself.
79. On 1 November 2006, the cellmate was segregated for allegedly attempting to rape another prisoner “at blade point”. A security incident report was completed. According to prison records, the allegation was referred to the police. An adjudication was opened and adjourned, pending the outcome of the police investigation. The investigator liaised with the police liaison unit at HMP Woodhill, where he was being held at the time of the investigation. They contacted Manchester police to clarify their response to this incident. Manchester police advised the investigation that they had not been notified about this incident according to their records, and therefore there was no evidence of any subsequent police investigation. The adjudication was not resumed so he was neither prosecuted nor adjudicated following this allegation.
80. An ACCT document was opened by the senior manager on the segregation unit. During the cellmate’s ACCT assessment, it was noted that the first charge of sexual assault against a prisoner (dating from December 2005) had been dropped due to a lack of evidence. There is no other record of this outcome in his files.
81. On 2 November, a risk assessment meeting was held to discuss whether to continue to accommodate the cellmate on the segregation unit. (A prisoner who has been identified as at risk of self harm should only be segregated in exceptional circumstances because of the restricted regime and support available in a segregation unit.) He acknowledged that he was “shocked” at his own behaviour and said that he “does not have control over his other irrational side”. It was agreed that his situation constituted exceptional circumstances

because he posed such a high risk to other prisoners and he continued to be accommodated in the segregation unit.

82. A cell sharing risk review was carried out on 8 November, where it was acknowledged in capital letters, that the cellmate had sexually assaulted a prisoner on the wing. The officer also recorded that he had made threats of a sexual nature to other prisoners and that he “continued to befriend vulnerable prisoners”. He remained on the segregation unit. On the record of the cell sharing risk review completed one month later, “sexual assault on cellmate” was noted. It was not clear from his records whether this related to the assault on 1 November or whether there was another incident. This comment was repeated in the cell sharing risk reviews on 8 January 2007.
83. An OASys risk review was completed on 19 January 2007. It noted that the cellmate had been “diagnosed with schizophrenia and personality disorder”. A worker from community supervision group recognised that he posed a risk to male members of the public and himself. However, she found that his risk to a known adult while he was in custody was low and the risk he posed to prisoners was medium. Nevertheless, the prison rightly continued to regard him as a high risk to other prisoners and he was accommodated in the segregation unit.
84. The cellmate’s last cell sharing risk assessment before his conviction on 8 April 2007 recorded that he was a high risk to other prisoners. The following was noted on the form:

“Alleged sexual assault on cell mate.  
Never self-harmed while on the seg unit.  
Alleged weapon used on sexual assault on cell mate.  
In daily contact with [mental health in-reach team].”
85. On 12 April 2007, the cellmate received a six and a half year sentence for male rape. It was still recorded on his prison escort record used when escorted to and from court, that he should be kept separate from the three prisoners identified the previous year and that he was convicted of a sexual offence. He was identified as “vulnerable”.
86. According to Prison Service Instruction (PSI) 32/2005 which governed cell sharing risk assessments at the time, there was no absolute requirement to review a prisoner’s cell sharing risk assessment upon conviction although the instruction required a re-assessment ‘if there is a significant event which triggers concern.’ The cellmate’s next cell sharing risk review took place on 8 May and exactly the same wording was used on the form, as used on the form dated 8 April and set out above.
87. Also on 8 May, Officer A completed the cellmate’s security categorisation, which was signed off by a SO. An “Initial Categorisation of Adult Male Prisoners” (ICA1) form, is completed when a prisoner is sentenced. An officer fills in the details of the form based on a prisoner’s pre-convictions and information available in the core record. The officer explained:

“When a prisoner is actually sentenced we collect all the core records, which is everything, all information that’s out together about a prisoner. We get information from the courts, we get previous convictions and we ... took them all to the OCA unit.”

The officer who completes it does not meet the prisoner unless they are being considered for a category D prison.

88. Officer A completed the provisional categorisation algorithm, noting that the cellmate was convicted of a sex offence and had previously been convicted of failure to surrender and breach of bail. Following the algorithm, the officer determined that he should be considered a category C prisoner.
89. The next page of the categorisation form invites officers to record any circumstances which indicate a prisoner should be placed in a higher security category than that suggested by the algorithm. It cites the following examples: “security information, significant control problem, circumstances of offence, pattern of offending or facing further charges of a serious nature”. Officer A ticked that no such circumstances applied in the cellmate’s case. He explained:

“If there was security information sent to us by the police or our Security Department saying he’s a risk to certain groups or individuals, that would be things you would actually put in there.”
90. The investigator asked Officer A whether the allegations that the cellmate had sexually assaulted prisoners on two occasions in custody would have been taken into consideration. He explained that as the cellmate had not been convicted of the offence, and neither had it be proven at adjudication:

“That wouldn’t affect him whatsoever.”
91. By contrast, the Head of Security at Manchester told the investigator that he would have expected the two allegations to have had a bearing on the categorisation assessment. However, the possibility of overriding the algorithm, allowed for in the form seems not to have been considered and the outcome of the categorisation assessment was that the cellmate was a category C prisoner, as defined by PSO 0900 – Categorisation and Allocation, “Prisoners who cannot be trusted in open conditions, but who do not have the resources and the will to make a determined escape attempt”.
92. The process of allocation is distinct from categorisation and takes into account the prisoner’s suitability for certain types of accommodation, for example if he is a vulnerable prisoner, medical needs, sentence plan and his home area, among other factors. As a convicted sex offender, Officer A recommended that the cellmate be allocated to the vulnerable prisoner unit at HMP Wymott. Around half of the population in Wymott are sex offenders.

93. Despite the investigator's request, Manchester could not confirm whether the cellmate was still in the segregation unit, the healthcare centre or on a residential wing at the time of his transfer. There was no PER for the journey to Wymott on 14 June, in the copied files received by the investigator and no reference to it at Wymott.

### **The cellmate's time at HMP Wymott**

94. Just over a month after his categorisation and allocation was complete, the cellmate was transferred to HMP Wymott, a Category C prison near Preston. Despite his offence, and Manchester's recommendation he was not accommodated on the vulnerable prisoner unit used for prisoners who are at risk from other members of the prison population such as those convicted of a sexual offence.
95. A cell sharing risk assessment was completed on the same day, 14 June 2007, by an officer. For the first time since the cellmate was charged with rape of an adult male in March 2006, he was not assessed as high risk to other prisoners. The officer noted that he was a smoker and that he "prefers own cell". In another section, the officer recorded that he was "afraid of cell sharing as he is gay. Will cell share with non-homophobic prisoner". He was assessed as a low to medium risk despite his offence and with no apparent reference to the security information and allegations against him.
96. On 12 July 2007, an entry was made in the cellmate's security file, as follows:
- "Intel from previous establishment, complaint from other prisoner that he had been raped by him and was facing charge in April 2006. Suspicion that he will try and groom vulnerable prisoners, and is open about his homosexuality. He was placed with health care due to his constant urges to cut a member of staff's throat and become sexually excited by the thought. Has no victim empathy. Wing informed."
97. The investigation team saw no other entry relating to this information in the cellmate's wing history record. It did not trigger a cell sharing risk review. There was no updated security information.
98. On 13 July, the cellmate told staff that he had swallowed two razor blades. He was taken to the local accident and emergency department for follow up, after an initial examination at the prison. An ACCT document was opened when he returned to the prison later that day. During the case review the next day, he told staff that he would "slash up to get a move to the VP side of the jail or the CSU", (CSU stands for Care and Separation Unit as the prison's segregation unit was known). He was told that he might have to go to another prison to complete the sex offender treatment programme (SOTP), identified as part of the sentence plan that he had to complete prior to being considered for release. Another entry was made on the security file, recording that "concerns about [his] threat to wreak havoc when released if he didn't get help logged on security file". He was identified as raised risk to himself and his ACCT remained open. He was referred to the mental health in reach team.

99. At the next ACCT case review on 23 July, the cellmate asked to go to Whatton or Stafford. He told staff that he felt he was being ignored by them. The ACCT document remained open following this case review, although it is not possible to determine when it was closed, because despite her request the investigator has not seen the record of the closing case review (although there was a post-closure review on 11 August).
100. A further security matter was logged on 10 August when staff received a letter addressed to the cellmate as the 'induction officer' about adoption. At the time the letter was received, he was running a drop-in centre for prisoners undergoing induction and was also an Insider. (Insiders are prisoners who usually work on first night and induction centres and offer guidance and information to new prisoners.) As well as possibly impersonating an officer, staff had observed him closing the door when speaking to several prisoners and was thought to be taking advantage of his position. He was removed from his post.
101. On 14 August, another ACCT document was opened after the cellmate cut his right leg. He was admitted to the healthcare centre where he underwent a mental health assessment. Over the following month, he was subject to ACCT monitoring following his self harm.
102. As part of his support plan, officers looked into why he was not located on the vulnerable prisoner unit at Wymott, which would enable him to complete the SOTP and advance in his sentence plans. Because Wymott was concerned about the risk that the cellmate posed, he was assessed as "not suitable" for the vulnerable prisoner unit and therefore had to be transferred to another prison to complete the programme. Had he remained at Wymott to do the SOTP outcomes might have been very different.
103. Although he had the support of staff to transfer to another prison, the cellmate needed a psychological assessment to determine which type of sex offender treatment programme would be most suitable. He continued to ask staff why he could not move to the vulnerable prisoner unit in Wymott to complete the SOTP, and there is no record of him being given an explanation. His solicitor wrote to the Offender Management Unit on 19 September to complain about their client's lack of sentence progression. By the time his ACCT was closed on 30 September, he had been assessed by the psychology department as suitable to complete the core SOTP programme and it was recommended that he to go to Stafford.
104. Towards the end of November, the cellmate told staff that he was suffering from seasonal depression and that he might harm himself. An ACCT document was opened and it was noted that he was to be accommodated in a single cell. The ACCT remained open for the rest of his time at Wymott.

## **The cellmate's time at HMP Whatton**

105. The cellmate remained at Wymott until his transfer to Whatton on 5 December 2007. The nature of his offence and his vulnerability were indicated on his PER, although there was no mention of the two allegations of sexual assaults against prisoners. Neither was there any mention of the security matters that prevented him from being accommodated in the vulnerable prisoner unit at Wymott but allowed him to be held in Whatton a prison populated only with sex offenders. There was no further reference to a transfer to Stafford which had previously been suggested.
106. Although we found no evidence that the cellmate's cell sharing risk assessment was reviewed during his time at Wymott, "\*\*High Risk CSRA\* was recorded in the 'Additional Information' section of the PER which suggests it had been changed at some stage. On arrival at Whatton a cell sharing risk assessment was completed. The majority of the form was left blank and, despite the high risk indicator on the CSRA, he was recorded as a low risk to other prisoners.
107. The PER indicated that the cellmate's ACCT document was closed, although he was transferred on an open ACCT. Nevertheless, the ACCT document transferred with him and the Whatton induction senior officer conducted a case review on 6 December, the day after his arrival at the prison. The senior officer recorded that he was "still a little anxious while he was settling in" and kept the ACCT document open. The day after this first case review, another review was held following a death in custody. (All prisoners on open ACCT documents should be reviewed following any death in custody.) The review noted that he was settling in and "is now sharing and is happy to have someone to speak to". The ACCT document was closed a week later.
108. A Safeguarding Children meeting was held on 12 December. At that time, all new prisoners were discussed at this meeting to determine if there were any risk factors which required additional security or public protection measures. The cellmate was discussed at the meeting on 12 December, as a new arrival. The meeting noted details of his index offence, his removal from the job of induction orderly at Wymott and the fact that there was an ongoing allegation of rape against a prisoner. It was also recorded that "he has urges to cut people's throats for sexual pleasure". The conclusion of that meeting was that he should be subject to monitoring as a risk to prisoners and staff and that his CSRA should be reviewed. (In fact, there was no evidence that his CSRA was reviewed as a result of this meeting.)
109. The cellmate's risk management was also referred for further consideration at the Interdepartmental Risk Management Team (IRMT) meeting, which also assessed how to best manage the risk every new prisoner presented. (The Safeguarding Children and the IRMT meetings have now been merged into one fortnightly meeting, designed to communicate and manage risk posed by prisoners.)
110. In line with Whatton's CSRA policy at the time, the cellmate's cell sharing risk assessment was reviewed on 29 December because he moved wings. His

wing move is noted on the form, but nothing else was written. No outcome of the review was recorded, and he continued to live in a double cell. Just two days after this review, a security report was submitted alleging that he was involved in dealing medication for sexual favours. There was no evidence that he was spoken to about this by staff or that any action was taken following this allegation.

111. The cellmate's cell sharing risk assessment was again reviewed on 3 January because he was moving cells. He continued to be assessed as a low risk. He was moved to share a dormitory cell on B wing with two other prisoners.
112. The IRMT meeting was held on 8 January. As the cellmate had been referred by the Chair of the Safeguarding Children meeting two weeks earlier, his risk factors were discussed, including that he "was investigated while at HMP Manchester over rape of another prisoner, no results of the investigation known". The police liaison officer at Whatton was asked to check the status of the police enquiry. As a result of his risk factors, it was decided to alter his CSRA to high and relocate him into a single cell.
113. That same day, the cellmate's cell sharing risk assessment was revisited by an officer and he was considered a high risk to other prisoners. The following note was made on the cell sharing risk assessment:

"The prisoner has been accused of raping two male prisoners in previous establishment.  
Has made threats to cut people's throats and especially a member of staff."

114. The cellmate was moved into a single cell on A wing. Also on 8 January, he had his first interview with the Offender Management Unit who noted that he had been sectioned three times, but had no other issues.
115. The cellmate took an overdose of 20 tablets on 28 January. An ACCT document was opened and a mental health referral was made. He gave staff a "cast iron guarantee" that he would not self harm, but described suffering from "bouts of depression". He told the mental health nurse that he took all his tablets when he received them at the beginning of the week and bought more medication from other prisoners. He claimed he did not suffer from withdrawal. The ACCT document was closed seven days later, when he was described as "buoyant and optimistic".
116. On 10 February 2008, the cellmate was interviewed for his cell sharing risk review. He said he did not know that he had been assessed as a high risk to share a cell because he had been cell sharing for some time. A SO carried out the interview. He recorded:

"The information noted is for an allegation of rape on two males at Manchester.  
I have asked for his security file to be checked before a thorough, informed review can take place".

117. A SO carried out a further cell sharing risk review the following day. He noted the following in the cellmate's ongoing record after their discussion:

"He accepts that his history could be seen as a potential risk but he has been sharing cells without any problems for over a year. [He was rated as medium risk with three reviews a year.] He is happy with this decision as he is very confident he will not pose a risk at all."

This was not the case as in February 2007 a year previously he was assessed as high risk at Manchester and held in a single cell during his time there. He also spent time at Wymott in a single cell.

118. The SO completed the cell sharing risk assessment form, indicating that he had spoken to the security department. The senior officer was advised by the security department that all intelligence about the cellmate's risk to other prisoners was more than two years old. They told the SO that there was nothing in his records over the last two years to suggest that he was a risk. HE continued to be in a single cell, although his risk was reduced to medium.

119. The cellmate completed a standard pre-SOTP assessment on 16 February. Among other questions, he was asked whether there was anything about his offending that he had not yet disclosed. He responded: "I also fantasise about being raped and acting out rape scene with sexual partners". In her report for Nottinghamshire police, the then Clinical Lead, commented on this extract as follows:

"This information was shared in the context of the Sex Offender Treatment Programme, and does not necessarily indicate imminent risk. Indeed, honest disclosure such as this is encouraged in treatment, so that men can address their risk factors appropriately."

120. On 16 March, the cellmate asked his personal officer to be considered for enhanced status. The officer explained that his behaviour had been "too unsettled" for consideration of enhanced status, and that he needed to demonstrate positive behaviour for at least a month before he would be eligible. The officer explained in interview that the cellmate often had disagreements with other prisoners and was "immature".

121. A group worker who facilitated SOTP interviewed the cellmate on 29 April as part of the assessment process. He discussed his background and his attitude towards men and women. She also asked him about his sexual history and he told her that he had had a lot of sexual partners. He said that he had "acted out rape scenes – both consenting". When asked what was "the most sexually satisfying" parts of his offence, he said that "the act, in a way I had the control over him". He went on to acknowledge that before the index offence he "had fantasies of people being asleep and them not knowing". Finally, he told her that he was attracted to "straight men".

122. In a further assessment two days later, the cellmate recalled the circumstances of his offence and reflected what he could have done differently. He explained that he acted on the “spur of the moment” and told the group worker that he wanted to complete the SOTP course “to get an understanding of why I committed the offence. To put things in place/change things so it doesn’t happen again/don’t come back to jail”.
123. The cellmate attended chapel regularly throughout his time in custody. On 2 May, he was recorded as “displaying a poor attitude towards chaplaincy staff and other prisoners”. He was restricted from attending all chaplaincy activities, apart from services on a Sunday and Wednesday. He responded badly to the restrictions and an ACCT document was opened.
124. In the following few days, the cellmate told staff that there had been some issues in the chaplaincy but he “held his hands up” and said “he was in the wrong”. He had acted inappropriately towards another prisoner. On 7 May, a Violence Reduction Strategy (VRS) document was opened. The VRS has three stages, the first of which is staff monitoring. He was placed on stage one and, as part of his support plan, he was encouraged to talk to prisoners he liked and think before talking.
125. Four days later, the personal officer recorded that the cellmate was upset to be put on a VRS document. He said “he hates bullies and is shocked at the suggestion that he is one”. The officer recorded that their conversation was a “pleasing interview, filled with positive points”.
126. The cellmate’s ACCT document was closed on 14 May, less than two weeks after it had been opened. He asked staff to be taken off the document, because he did not feel in need of the additional support and he did not want it to affect his chances of getting on the SOTP. The same day, he was sent an invitation to attend the core sex offender treatment programme.
127. Just four days later, the cellmate started his sex offender treatment programme. On the second day of the programme, he walked out of the course, but staff on his wing were not informed. It was him who told his personal officer that he had left the course. That day, he also saw a nurse, complaining of dizziness and “stabbing in the left chest into the left arm”. The nurse speculated that the symptoms might be related to the reduction in his mental health medication and suggested monitoring for a week.
128. On 21 May, the VRS document was closed. It was noted that he had been “no cause for concern over previous 14 days” and that he was speaking to the prisoner who he disagreed with, thanks to mediation sessions co-ordinated by the chaplaincy.
129. A forensic psychologist in training interviewed the cellmate on 4 June 2008 for his suitability for the core SOTP. The aim of the interview was determine whether he had any psychopathic traits and whether it would have an impact on the SOTP. He was assessed as suitable to continue with the core SOTP.

130. A scheduled review of the cellmate's cell sharing risk assessment took place on 23 June. A SO recorded that there had been no information from the security department in the previous three years. He went on to write in his wing history:

“CSRA assessment done. On reading last review when it was felt that he should be dropped to low, I see no problems with this as there has been no real concerns with him in the last three months. CSRA now low.”

His risk to other prisoners was assessed as low. He was recorded as, “pleased to be reviewed to low standard. To be reviewed in three months”.

131. On 25 June, the cellmate was challenged by an officer about why he had been observed “hanging around” a particular landing “on a regular basis”. He told the officer that he was waiting for chapel. The officer noted this exchange in his wing history, recommending that staff remain “aware” of this behaviour. However, there is no evidence that a security report was submitted.
132. A security report was made following an allegation made against the cellmate by another prisoner on 1 July. The prisoner alleged that he made inappropriate sexual comments to him. An equal opportunities form was submitted and the information was added to his security file.
133. The cellmate's personal officer spoke to him about the prisoner's allegations four days later, on 5 July. The officer recorded that he was “very upset” at the possibility of being placed on another VRS. He said that “he was trying very hard to get on with his sentence and coming to terms with doing the SOTP course”. He told the officer that he did not deserve to be on the VRS document again.
134. A VRS document was opened again on 8 July, in connection with the allegations the previous week. In the VRS document, it was noted:
- “Information received by a PO that he has previously raped three male prisoners.  
Accused of sexual assault of a prisoner in 2005.”
135. A SO sent the following email to staff on the cellmate's wing:
- “In order to comply with Whatton's VRS procedures, I need to inform you that he has been placed on Stage 1 VRS, after allegations of inappropriate sexual comments were made against him by another prisoner. As he is currently participating in SOTP and spends much of his free time in the Chapel, could you inform staff of his conduct on a daily basis, if staff in your department have contact with him.”
136. The cellmate appealed against the decision to open a VRS document, but it was rejected. This is recorded in the VRS ongoing record. None of the allegations or the fact that he was put on a VRS resulted in a review of his CSRA.

137. On 14 July, SOTP facilitators visited the cellmate's wing to establish why he had missed about ten sessions. Officers investigated and discovered that there was a healthcare related matter. The facilitators warned that he would be taken off the course if he missed more sessions. Facilitators agreed to call the wing if he missed another session. A compact was drawn up, whereby he agreed to attend the SOTP course.
138. The same day, the cellmate approached an officer to volunteer to share a cell. The officer recorded the following entry in his VRS document, following their conversation:
- “ ... it has been agreed by myself, another officer and a PO that this would be inappropriate in view of recent allegations and this current VRS document.”
- Although the officers recognised that it was inappropriate for him to share a cell at this stage this did not trigger a review of his CSRA.
139. The next day, the cellmate asked his personal officer “to record the fact that he wants more support from wing staff due to him struggling with the SOTP course”. The officer recorded the conversation in his wing history.
140. On 16 July, the cellmate breached his compact by failing to attend the SOTP course again. He assured staff that he was fully committed to the course and it was agreed that the compact would be reviewed in six days.
141. Six days later, the cellmate walked out of the SOTP course again after a disagreement in the class. He returned after five minutes. Despite the short time away from the course, it was still considered to be a breach of his compact. He was given one more week to demonstrate his commitment to SOTP.
142. On 23 July, the day after the above incident, a SO closed the cellmate's VRS document with an officer. He recorded that there had been no repeat episodes and that he had been polite and respectful when talking to staff.
143. The SOTP 'block' of work addressing patterns in offending behaviour concluded on 24 July. According to his SOTP progress report, the cellmate disclosed that he did not want to offend again in the future and that was his motivation for staying on the course. However, he acknowledged that he continued to have thoughts of “rough sex” and was encouraged to consider how these patterns of thinking could be risky for him in the future.
144. The next 'block' concluded on 31 July and encouraged the cellmate to reflect on social and emotional functioning, as well as self-management. He discussed his “preoccupation with sex” and was recorded by the treatment manager as having “a good grasp on the areas relevant to him”.

145. The cellmate made an application to move from A wing to the second or the sixth landing on B wing on 1 August. The application was sent to the allocation department. The next day, he told his personal officer that he had more problems with prisoners in the chapel that morning. He told the officer that he wanted to move wings to get away from a particular prisoner who was accommodated on the same landing as him. Each time a prisoner moves cells, his cell sharing risk is reviewed. An officer completed a cell sharing risk review on 3 August and again assessed him as low risk to others.
146. The cellmate was moved to a dormitory cell on B wing, sharing with two other prisoners on 4 August. A further cell sharing risk review was completed by an officer and signed by a manager. It confirmed an officer's assessment that he was a low risk to other prisoners when sharing a cell.
147. The Clinical Lead of the SOTP at Whatton at the time of the investigation, explained that one 'block' of the course concentrates on victim awareness. She told the investigator that prisoners often find this element of the programme difficult. As part of victim awareness, the prisoner writes a letter to their victim. The letters are not sent, but are intended to promote understanding of the effect of their actions on the victim. The cellmate wrote a letter to his victim on 9 August 2008. A report was prepared for Nottinghamshire police by the SOTP Clinical Lead at the time of the man's death, reviewing his interaction in the SOTP course. The Clinical Lead described the letter to his victim as follows:
- "This victim letter was a good one; he recognised the harm done to the victim; he reassured the victim that he was getting help for his offending behaviour; he recognised the harm done to the victim. Indeed, this would be a good letter if it was the second victim letter written by a group member."
148. The cellmate approached a member of the Sentence Management team on the 12 August because he was concerned that he only had six weeks to complete his sex offender treatment programme and still did not have a sentence plan. An email was sent to his probation officer for an update. A Treatment Needs Analysis was also begun that day, setting out a plan to addressing his offending behaviour.
149. On 16 August, the cellmate was moved to a double cell on the third landing of B wing. On 19 August, he was told that he would be having a telephone conference with his Offender Manager in September.
150. The third VRS document was opened on 20 August by a SO after it was suspected that the cellmate had "taken advantage of" another prisoner in the chapel. The SO noted that he had been the subject of another VRS for "attempted grooming". The incident was documented in his IEP record, but there was no corresponding Security Information Report. There is also no evidence that his cell sharing risk assessment was reviewed on this occasion.
151. In the ongoing VRS document, Officer B recorded that he had a "good lengthy chat" with the cellmate on the morning of 21 August. He said that they had

previously “not seen eye to eye”. He suggested that he might have turned over “a new leaf”. Later that day, he approached the officer and asked whether he could have a cellmate because “he is getting a bit stressed on SOTP and would like the company”.

152. In his statement to the police after the man’s death, Officer B said that he did not remember the first conversation he recorded with the cellmate. He went on to say that he “could not recall whether he had such a conversation or not”. The officer confirmed that he was not personally involved in relocating him into a shared cell, but just recorded the conversation in the ongoing VRS document. He told the police that he did not make recommendations about cell sharing but “may have referred to a [senior officer] verbally that he was asking [to share a cell]”.
153. An officer recorded a conversation with the cellmate the next morning at 9.30am. He said “he was happy at present, but just wondering when his cell is being doubled up”. (‘Doubled up’ is an expression for turning a single cell into a shared cell.) The officer reassured him that it would “probably take place soon” and recorded that there were “no concerns seen at present”. At 12.15pm, he added a further entry to the VRS, recording that a prisoner from induction had moved into the cell. When he asked him about it, he assured him that he had been wanting to share.
154. Over the next few days, the cellmate was observed associating well with prisoners. Officer B described him as “his usual social self” and commented in the VRS document that he “seemed to be getting on well with his new cell mate”. The officer said he had no concerns at all and the “signs at this time are very encouraging”. The officer confirmed in his police interview that “he had no reason to suspect there was a problem between them”. He had a visit from his family on 24 August, and a further visit was scheduled for the following day, Bank Holiday Monday 25 August.

**Events of the incident**

155. The investigator reviewed the CCTV footage of the landing outside the cellmate’s and the man’s cell in the afternoon and night of the incident. Staff made statements to police in the days following the man’s death. Three years later they were interviewed by the investigator. There are differences between the accounts of staff, the CCTV and the evidence they recalled in interview for this investigation. The CCTV footage has been set out in tables below, followed by a summary of statements. There is no suggestion that staff have been deliberately misleading to the police or the Ombudsman’s investigator. The difference in accounts is more likely to reflect the traumatic nature of the events of that night and the protracted nature of this investigation.

*Afternoon of the incident*

Time	Event
3.00pm	CCTV footage starts.

	Cell door open but neither the man nor the cellmate are visible on the footage. Two prisoners are in the communal areas in front of the CCTV camera.
3. 04:51	The man stands in doorway of cell wearing jumper.
3.05:20	The man comes out of the cell and closes the cell door behind him. Walks towards the CCTV camera and walks off screen. Doors stays closed.
3.17:00	The man returns to his cell with a plastic bag. Opens door and enters cell.
3.17:41	The man leaves the cell and waits in line to get water from the tap next to his cell.
3.18:00	The man walks away from the water tap with a flask and returns to his cell. Door remain open.
3.18:24	The man leaves his cell with a kettle and gets more water.
3.18:49	The man returns to his own cell.
3.19:37	Leaves the cell with his kettle and again seems to go to the tap.
3.19:50	Returned to the cell and cell door remains open.
3.27:26	Door pushes to from the inside.
3.29:01	Door opens from the inside.
3.29:18	The man leaves cell and walks away from the CCTV camera. He reads the noticeboard carefully.
3.29:49	The man returns to his cell and his door remains open.
4.04:56	The cellmate returns to cell.
4.05:09	Cell door pushes to from the inside.
4.06:35	Door opens from the inside. The cellmate leaves the cell and the door stays open behind him. Walks towards the CCTV camera and off camera.
4.07:00	CCTV stops.
4.27:00	CCTV starts again.
4.27:52	The cellmate walks back on camera and into cell.
4.28:22	Male member of staff leans into cell and closes the door. Member of staff locks the door.
4.31:00	CCTV footage stops.
7.25:00pm	CCTV footage resumes.
7.25:47	Female member of staff looks through observation hatch.
8.11:42	Male member of staff looks through observation hatch.
10.59:07	Male member of staff walks onto wing and walks to the other end of the wing, away from the CCTV camera.
10.59:10	Another officer follows and wanders near the cell, opposite the man's cell.
10.59:37	Male member of staff walks off camera.
10.59:50	Other male member of staff walks back down wing corridor and off camera.
11.01:00	CCTV summary stops.

156. The man spent more time in the cell, but the cellmate occasionally went back to the cell throughout the afternoon. Both were locked in their cell at 4.28pm. They were then checked again at 7.25pm by an officer during a roll count. (A roll count is carried out by officers to check the number of prisoners on the wing.) She told the police that she could not specifically remember looking

through the cell observation panel, but was confident that there was nothing out of the ordinary at that time.

157. The closed circuit television camera (CCTV) footage showed a member of staff looking through the observation panel of cell B3 33 at about 8.10pm. An Operational Support Grade (OSG) 1 said in police statement that this was done by OSG 2, who was also working on B wing that night. OSG 1 started the night shift at 8.15pm. In a police statement, he described the duties as “checking on the vulnerable prisoners, checking basic security and answering the cell buzzers”. At the time of the man’s death, he explained that he only worked night shifts and therefore did “not interact with the prisoners, unless [they press] their cell buzzer”. He said that he did not carry any keys with him throughout his shift. (It is possible that the OSG was referring to standard prison keys as all night staff should have cell keys in sealed pouches for use in an emergency.)
158. According to OSG 2’s police statement, he started his shift at 8.45pm. However, in interview for this investigation, he clarified that his shift started at 8.45pm but he would often arrive earlier in order to receive a handover from the staff on evening duty. OSG 1 remembered the other OSG was already in the central office when he arrived on the wing at 8.15pm and did the roll count. At the time of his interview, OSG 2 could not remember whether he had completed the roll check that evening, but if anything had been a matter of concern, he would have raised it with his manager and recorded it.
159. In line with their duties, both OSGs patrolled the units that make up B wing and responded to cell buzzers. OSG 2 told the investigator that it was a quiet shift that evening. He explained that he responded to cell buzzers around the wing and completed a ‘pegging check’ (a patrol around the wing which is recorded via electronic points stationed around the wing). At that time, he said that staff on B wing at night would wait in the central office for cell buzzers to be activated. The central office was located on a lower floor from the man’s cell, down two flights of stairs.
160. The CCTV footage showed one male member of staff walking from one end of the landing to the other at 11.00pm. In the meantime, OSG 2 walked into the shot of the CCTV camera, and hovered at the end of the wing in the area of the man and his cellmate’s cell. The investigator asked him if he could remember hearing anything at that time. He said that he could hear television and parts of conversations from inside cells. However, on that occasion, he could not remember hearing anything that concerned him on the B3 landing.

*Responding to the cellmate’s cell bell*

<b>Time</b>	<b>Event</b>
12.31am	Two men walk to cell (not visibly carrying radios) Look through hatch one at a time
12.31:58	Walk back towards the CCTV and off camera together
12.36:15	A man walks to the cell and talks through the observation panel.

12.36:50	Man closes the hatch but then reopens and continues to talk.
12.37:00	Another man walked into view towards the man's cell stopped and then walked off camera. Other man remains at observation hatch apparently talking through the observation hatch.

161. In his police statement, OSG 1 said that at around 12.34am, he responded to a buzzer activated by someone in cell B3 33. In the statement, he said:

“I came back to the office and turned it off and then made my way to cell B3 33 where the call had come from. I did not rush as usually it is not an emergency, so I took a fast walk up the stairs to the cell.”

162. The OSG told the police that he went to the cell alone. OSG 2 remembered being in the central office when the cell bell sounded. He said that a light turned on and there is a sound when the cell bell is activated. He recalled responding to the cell bell and said that OSG 1 followed him to the man's cell. OSG 2 estimated that it took about a minute to get from the central office to the cell, up two flights of stairs.

163. Both OSGs remembered opening the observation panel and seeing the cellmate's face close to the window. He said, “I'm hearing voices, I can't get them to stop, I think I'm going to do something really bad”. OSG 1 said he asked him to calm down, but he insisted that he wanted to see the night manager. Throughout the exchange the OSG said that the cellmate's face was pressed up to the glass and he could not see into the cell. He described him as “very distressed and on edge, his eyes were wide and he was very agitated”. He assured him that he would get the manager and went to the landing office, a few doors down from the cell on the same level.

164. In his statement, OSG 1 said that when he left the cell he went to the central office and contacted the Night Orderly Officer (NOO), who was operationally managing the prison overnight. He reflected to police that he was “not alarmed to start with as many of the prisoners suffer from mental health issues”. The senior officer said that she would be there as soon as she could with the assistant orderly officer. Once he had spoken to her, he said that he went back to the cell and continued to talk to the cellmate through the door. He estimated that this was approximately 12.36am.

165. OSG 2's recollection was that it was he who contacted the night orderly officer, via the control room. He said that he then left OSG 1 talking to the cellmate while he looked for his prison history file stored in the landing office. He explained to the investigator that he was checking whether he had a history of mental health problems. He said that he did not get an opportunity to look at the file before the other OSG called him back to the cell.

166. OSG 1 told police that when he went back to the cell on the second occasion, he asked the cellmate whether he was “okay”. He replied:

“I've done something really bad; I think I've killed my cell mate.”

167. In his statement, OSG 2 described the cellmate’s voice as “very panicky” and said that he was pacing around his cell. He said that he had suffocated his cell mate and confirmed that he was on the top bunk in the locked cell. It was at that point, that he told his colleague about the claims. OSG 2 went back to the landing office and telephoned the communications room to “explain what had been said”.
168. OSG 1 remained at the cell, reassuring the cellmate that he would not be hurt by staff and trying to help him remain calm. The cellmate asked him to stay with him, and he continued to comfort him through the observational window. Eventually, the OSG said that “His eyes were vacant, he was still on edge but his body seemed quite relaxed. There was no anger in him at all”.
169. OSG 2 told the investigator that OSGs are not qualified to open a prisoner’s cell at night. He explained that they are not trained in Control and Restraint (the techniques used by the Prison Service to control refractory prisoners). He said that they had to wait for their line manager to attend the cell before they door could be opened. In fact all night staff, including OSGs, are provided with a cell key in a sealed packet in order that they may enter a cell in the event of an emergency. Prison Service guidance is that ...’because of the security implications of opening a cell at night when there are only a small number of staff on duty, all night patrol staff are trained to radio for assistance from the Night Orderly Officer in the event of discovering an incident. After assistance has been summoned an operational judgement must be made by the patrolling officer about whether to enter the cell or await assistance. This will depend upon the nature of the incident, the circumstances in the cell and the need to maintain safety and security whilst responding to the incident’.

*The arrival of the orderly officer and her assistant*

Time	Event
12.41:50	Man still talking through obs hatch. Two men and one woman return to the cell and look through the panel.
12.42:50	All staff leave the cell locked and unattended.

170. The NOO was in the communications office when she received the OSGs’ messages about the cellmate. After the first message was relayed to her by the communications OSG, she spoke to her assistant, who was in a neighbouring office. She told the investigator that it was not unusual to be called to a cell during a night shift and the reasons for her attending varied greatly. She explained that even after the first message she treated the call as urgent, because anything requiring her assistance during a night shift could be an emergency situation. She did not remember being told that the cellmate had claimed to kill his cellmate at that point. She told the police that OSG 1 sounded “stressed”, and she assured him that she was on her way with her assist. (In interview for this investigation, she could not recall whether she spoke to one of the OSGs directly or via the communications OSG.) The

assistant NOO remembered being told by the communications OSG that the cellmate claimed to have killed his cellmate.

171. The NOO and her assistant made their way “at pace” to B3 landing. She said that there were several locked doors between the communications department (located above the staff entrance to the prison) and B wing, and both she and her assistant carried keys. She said that they are not allowed to run for health and safety reasons, but walked as quickly as they could. According to the CCTV footage, nearly five minutes elapsed between OSG 2 walking off camera towards the landing office and them arriving at the cell.
172. The NOO said in her police statement that when she arrived on the wing with her assistant, she was told by OSG 1 that “the cellmate had said he was going to kill him”. She said she understood that as “he was going to kill his cell mate”. According to the CCTV footage, OSG 2 accompanied them to join OSG 1 outside the cell.
173. Each officer looked through the observation window. The assistant NOO recalled in interview that the cellmate’s face was against the observation window. The officer asked him what had happened and when he said he had killed his cellmate, he said “What?” He told the investigator that he did not think he had heard correctly. He asked him to move to the back of his cell so that he could see the man. He said that he wanted to satisfy himself that it was “not a decoy”. The officer told the police that he could see another man lying on the top bunk completely covered by a sheet and asked the cellmate to remove it. At that point he could see his:

“feet, the back of his legs, his bottom, his back and the top of his head, I watched his feet, they had no colour to them and the male wasn’t moving at all.”

*While Orderly Officer collected additional staff*

<b>Time</b>	<b>Event</b>
12.43:20	Man returns to cell
12.43:50	Leave cell unattended
12.46:43	Man returns to cell, stays for two seconds and then leaves cell unattended.
12.47:46	Man goes to the cell next door, closes observation hatch and walks off camera.
12.48:30	Man walks past cell to the end of the corridor away from the CCTV camera.
12.49:30	Man walks back to the cell carrying an object – possibly defibrillator
12.49:50	Man leaves cell unattended.

174. The assistant NOO told the police that he stayed with the cellmate throughout the time it took for the NOO to collect other staff. The NOO thought she had asked him to remain at the cell until she returned. In fact, during the nine minutes it took for two officers to be collected by the NOO, the cellmate was

largely left with the man on their own in the cell, unattended by officers. During interview for this investigation, the assistant NOO was surprised that he had not stayed with him, as he remembered having a long conversation with him. He said that he would have had to check that there was an empty cell on the landing for him to be moved to, in the event that his claims were true. He said he would therefore have had to go to the landing office and see which cells were available and then check that cell to make sure.

175. The NOO, in the meantime, contacted the control room to let officers know that they would be needed for security purposes in advance of her getting to the wing to collect them. She then walked to A wing and collected two officers and returned to B wing at about 12.51am, nine minutes after she left B wing. According to the officers, she was not sure about whether the cellmate had claimed to kill his cellmate. She told the investigator that she explained to the two officers why they were needed and the nature of the cellmate's claims.
176. OSG 2 accompanied the NOO to A wing and was asked to cover officers' duties on A wing. He therefore remained on A wing once all of the officers had left. OSG 1 said that he "stood back" once the NOO had arrived, explaining that as an OSG he was "not allowed to enter cells or deal physically with prisoners".
177. The NOO said that they needed five members of staff present to remove him from his cell due to the cellmate's "demeanour". She explained to the investigator that he seemed intimidating as he was striding around and she needed to assure herself that her staff and the prison were not at risk before the door was opened. She therefore required staff who were trained in Control and Restraint.

*Going into the cell*

<b>Time</b>	<b>Event</b>
12.49:50	Man leaves cell unattended.
12.50:16	One member of staff goes to the man's cell door and speaks through the hatch.
12.50:50	Joined by two more members of staff
12.50:57	Joined by two more members of staff
12.52:17	Five members of staff present. Cell door opened. Man walks out calmly and is searched outside the cell. (The cellmate) No one enters cell at this point.
12.53:20	Man walks down corridor, accompanied by members of staff. One male member of staff remains at cell. Leans on door
12.54:16	Male member of staff goes into the cell
12.54:30	Male member of staff leaves cell
12.54:56	Male member of staff and a number of staff members go back into cell.
12.56:40	Male member of staff picks up object (defibrillator?) from outside cell.

178. At 12.52am, with five members of staff present, the cell door was opened. Each member of staff recalled events differently in their police statements and interview. According to the CCTV footage, the cellmate calmly walked out of the cell and was searched by the assistant NOO. No-one went into the cell at this point. A minute later he walked down the corridor to the new cell assigned for him by the assistant NOO. He was accompanied by two officers and the NOO.
179. The assistant NOO remained at the cell and lent on the door. He told the investigator that he was trying to get a response from the man. He explained that he was still not certain that he was dead, and this was not an attempt to breach the prison's night security. He shouted at him, but got no response. He said that he went into the cell with an officer in order to make sure he had assistance if the man tried to assault him. According to the CCTV footage, he was alone when he went into the cell at 12.54am. In his police statement, the officer said that he went into the cell and touched the man's foot. He told police "the male was cold and very stiff, there was no response". In interview for this investigation, he said he thought it likely that his condition was serious, but was still unsure. Although he did not recall it in interview, the assistant NOO then left the cell briefly and returned with an officer.
180. The assistant NOO continued to try and get a response from the man and eventually he and an officer turned him over. He said that he wanted to move the man to the floor because he understood that resuscitation is more effective on a hard surface. However, due to the man's weight and his position on the top bunk, he was concerned that he risked losing control of him and causing him further injury when lowering him to the floor. He decided to check his vital signs and begin resuscitation on the top bunk. He said he climbed onto the top bunk, where he lay to look at his face, check whether he was breathing and check his pulse. He said his skin colour and appearance did not look good.
181. The NOO returned from relocating the cellmate and asked the assistant what his impression of the man's condition was. He told her that it was serious and that the cellmate's claims of murdering his cellmate may be true. They agreed that she should contact the communications room to call the police, paramedics and Duty Governor. She walked to the landing office and instructed the communications OSG to do so. The assistant NOO started resuscitating the man, using two breaths to 30 chest compressions (in line with Resuscitation Council (UK) guidelines).
182. At 12.56am, an officer lent out of the cell and picked up the defibrillator from where OSG 1 had left it earlier. The assistant NOO set up the defibrillator and the officer left the cell to take over the log, which had been started by the NOO. By this time, the NOO had left B wing to escort the paramedics from the gate to the wing. During this time, the assistant NOO was continuing resuscitation on his own. Both officers both told the investigator that they offered to help him, but he refused their assistance. The assistant NOO told the investigator that he was confident in resuscitation, there was restricted access to the man on the top bunk of the bed and it would have been awkward for another officer to help

him. He was also conscious that he wanted to preserve evidence in the cell in what was likely to be a crime scene.

183. A paramedic told the police that the ambulance received emergency response call at 1.09am to attend a possible suffocation at HMP Whatton. No further details were given. He said they arrived at the prison at 1.22am and a female prison officer took them to the incident.
184. At 1.23am, the paramedics arrived and went into the cell. They applied their own defibrillator, while the assistant NOO continued with chest compressions. The paramedics' defibrillator confirmed that the man had no heartbeat. In his police statement, the paramedic said that because the alarm was raised at 12.34am and resuscitation did not start until 1.00am, and there had been no change in condition in the meantime, the paramedics did not continue to attempt resuscitation. The man was pronounced dead at 1.35am.

### **Prisoner support**

185. The morning after the man's death, prisoners were asked to remain in their cells until the police had completed their evidence gathering procedures. The cellmate was removed to the segregation unit and remained there until he was taken into police custody. Once prisoners could leave their cells, staff spoke to them about the events of the previous night. They were reminded that they could speak to a Listener and members of the chaplaincy also made their presence known. All prisoners subject to ACCT monitoring were reviewed to determine whether their level of risk had been affected by the distressing events of that night.

### **Family liaison**

186. The man's mother was listed as his next of kin. As there was to be a police investigation into the circumstances of the death, the Governor and the family liaison officer gave the family their contact details and asked them to call them should they require anything. The police's family liaison officer took over the main liaison with the family, to ensure that they were kept up to date with the progress of the criminal investigation.

### **Liaison with offender's family**

187. The cellmate's parents had visited him the day before the murder. They lived some distance from Whatton and had accumulated visiting orders. They were due to visit him the day following the incident. They arrived at the prison to visit their son, but were told that he was not available that morning. They were asked to wait until someone was available to speak to them about the events of the previous night.
188. The cellmate's mother wrote to this office about the length of time that she and her husband were left to wait in the car park of the visitors' centre, until someone came to explain that their son was believed to have killed his cellmate. Such circumstances are thankfully incredibly rare, but the family

suffered real distress at the delay in providing an explanation as to why they could not visit their son. Given the seriousness of the circumstances, it is more surprising that they were not told immediately of their son's situation.

### **Staff support**

189. All staff except one interviewed by investigators said they were well supported by the management team at Whatton in the aftermath of the man's death. On the morning of 25 August, the Governor held a hot debrief (a meeting of all the staff who were involved in a major incident, which focuses on reassurance, information sharing and how staff can support each other), which all present found helpful. Most felt well supported throughout the protracted investigation process following a homicide in custody except one who did not feel that she had been supported by the Governor. She said she did not know how to access staff care and welfare services, although we found that efforts were made to give her such support.

## ISSUES

190. The man was murdered by his cellmate in their shared cell. Accordingly, the investigation examines whether it was reasonable for the cellmate to be sharing a cell with another prisoner, taking into consideration cell sharing risk assessments, violence reduction strategy, sharing of security information and how serious allegations regarding prisoner on prisoner assaults are dealt with in the prison system. His categorisation and the transfer of information between prisons may also have had a bearing on the events of that evening and merit consideration.
191. The cellmate did not comment throughout his interview with the police. He refused access to his clinical records for the purpose of the Ombudsman's investigation. References are made in ACCT documents to his poor compliance with mental health medication that he was prescribed in the months before the man's murder. Had the investigator had access to all of his medical records, we would have commissioned a clinical review to reflect on whether his non-compliance with his medication adversely affected his state of mind at the time of the murder, and whether staff working with him, both on the wing and on his sex offender treatment programme, were sufficiently aware of his medical condition.

### **Should the cellmate have been in a shared cell?**

#### *The timeliness of cell sharing risk assessments*

192. At the time of the man's death, instructions about the purpose and operation of cell sharing risk assessments were contained in Prison Service Order 2750 – violence reduction. The purpose was set out as follows:

“The purpose of the risk assessment tool remains the same to:

- “draw together information about risk
- make best use of documentary evidence;
- support staff judgement about allocation to cells and risk management;
- record additional operational precautionary measures for a prisoner identified as a potential risk, where cell sharing is unavoidable;
- provide a record about risk of harm to others as a prisoner moves between wings/ prisons;
- to enable early identification of racist, homophobic or violent prisoners, to ensure that other Prison Service procedures to protect potential victims are followed.”

193. The cell sharing risk assessment system required that a CSRA was carried out when a prisoner arrived at the prison, and was reviewed either at pre-determine intervals, or in response to a wing move or other events that may have a bearing on the assessment of risk that the prisoner posed to others. Some examples of when a review might be triggered were listed such as ‘repeated or escalated threats of violence, particularly towards cellmates; discharge from segregation following violent or threatening behaviour; unexpected conviction

or harsh sentence', but the instruction said that circumstances for triggering a review were for local judgement. The instruction required prison staff to ensure that the focus of cell sharing risk assessments – the 'personal safety of cellmate' was maintained.

194. The instruction noted that 'A prisoner with a history of violence in custody (situational violence) presents a heightened risk' and a prisoner 'who is known to have armed himself with a weapon whilst in custody should be managed with extreme care.' Over the course of his custody, the cellmate had been involved in repeated incidents. On 1 November 2006, he admitted threatening his cellmate with a razor blade and forcing him to perform a sexual act.
195. A review of the cellmate's cell sharing risk assessments demonstrated that risk reviews were held in response to the examples listed in PSI 32/2005 but it did not appear that local judgement was used in other cases such as when he was subject to VRS. There was a concerning lack of records from the six months he spent at HMP Wymott.

*The timeliness of the cellmate's CSRAs at HMP Wymott*

196. As soon as Manchester was notified of the cellmate's charge of rape, he was assessed as a high risk to share a cell. Despite monthly reviews in the 15 months he remained at Manchester, he was always considered high risk. On 6 November, he was segregated after allegedly attempting to sexually assault a prisoner with a weapon. There is no record of whether he left the segregation unit before his eventual transfer to Wymott on 14 June. What is clear from the records is that he spent a number of months in the segregation unit following this alleged assault.
197. On arrival at Wymott on 14 June, the cellmate was assessed as "low/medium risk". The apparent lack of a PER for the journey from Manchester to Wymott is a major omission. The investigator spoke to the Safer Custody Manager about the CSRA process. She explained that the senior reception officer received a core file when a prisoner arrives at Wymott and looks through it to determine ant relevant information for assessing risk to other prisoners. She acknowledged that there is a time pressure when a prisoner is going through the reception process. Nevertheless, she was confident that cell sharing risk assessments were completed effectively. It is difficult to see how this could be the case if a PER was not used for a new arrival.
198. The Safer Custody Manager told the investigator that a prisoner should not be assessed as "low/medium" risk. The officer completing the form should have judged whether that prisoner was "low" or "medium". She said that she would expect a cell sharing risk review to be held every three months if such a judgement was made.
199. The investigator asked the Safer Custody Manager if she was surprised that the cellmate's risk had reduced so suddenly from "high" at Manchester, to "low/medium" at Wymott. She agreed that she would expect a more gradual reduction in the level of risk. The safer custody manager also explained the

reason for any CSRA judgement should be documented on the CSRA form, especially when there has been such a dramatic reduction in risk. No manager picked up on the fact that he was assessed as having reduced so suddenly. There is no formal audit system in place to assess the effectiveness of the first CSRA judgements.

200. There was no record that the cellmate had any further cell sharing risk assessments at Wymott. The only indication that his risk was reviewed was that his PER from Wymott to Whatton on 5 December indicated that he was a "H [igh] CSRA". While at Wymott, he was accused of grooming other offenders, kept separate from vulnerable prisoners due to an unspecified security risk and segregated. However, the investigator has not seen any evidence of further cell sharing risk assessments, despite her requests and these obvious triggers such as the security file entry on 12 July 2007 which recorded concerns at Manchester about his alleged rape of another prisoner and his urges to cut a staff member's throat.
201. The lack of cell sharing risk reviews may have had a serious impact on the subsequent assessment of the cellmate's risk. It demonstrates that staff at Wymott did not consider re-assessing his risk in light of the allegations of grooming on the induction wing and the unspecified security threat he posed to other prisoners on the vulnerable unit.
202. As the cell sharing risk assessment was noted as 'High' on the PER, on his transfer from Wymott it is possible that reviews were conducted but not appropriately filed with the cellmate's records. Not only has that resulted in a compromised audit trail for this investigation, but also undermined the information available for those making subsequent assessments. The apparent lack of a CSRA on transfer from Manchester is likely directly to have led to an inaccurate assessment.

#### *The cellmate's CSRAs at HMP Whatton*

203. The cellmate arrived at Whatton on 5 December, with a PER that noted his "CSRA H" ('H' indicating High). The CSRA completed on 5 December by reception staff at Whatton assessed that he presented a "low" risk to other prisoners. The sparsely completed form suggested that there was "insufficient information" to give a medical opinion about the risk that he presented, despite having two years of custodial records. As a result of this judgement, he soon found himself located in a dormitory cell with two other prisoners.

**The governors of HMP Wymott and HMP Whatton should ensure that all initial cell sharing risk assessments are based on information contained in a person escort record (PER) and security and other information available at the time of a prisoner's arrival.**

204. Once the security information was finally acted upon in January 2008, the cellmate's CSRA was reviewed to reflect that he presented a high risk to other prisoners on the basis of his past behaviour in custody: his history of alleged assault. In the light of serious security information, a cell sharing risk review

was appropriately triggered and his risk to other prisoners was appropriately identified as high.

205. On 11 February 2008, a SO revisited this assessment. He recorded:

“[The cellmate] accepts that his history could be seen as a potential risk but he has been sharing cells without any problems for over a year.”

On the basis of his self report that he had been sharing a cell for over a year, the SO adjusted his CSRA to reflect that he posed a medium risk to other prisoners but this information was inaccurate and should not have been relied on.

206. The cellmate’s CSRA was revisited when he moved cells or wings. It was reviewed when he was put on the first two of his VRS documents. However, when the third of the documents was opened on 20 August, no cell sharing risk review was held. Whatton’s own VRS policy recognises the important link between allegations of bullying and risk to other prisoners.

**The Governor of HMP Whatton should ensure that staff review cell sharing risk assessments when a VRS document is opened.**

*Were there indications that the cellmate was a risk to other prisoners?*

207. When reviewing the risk a prisoner posed to others, officers were asked to consider a certain set of questions. Below we have created a table listing those questions, how they applied to the cellmate, where the evidence was recorded in his file and any actions taken by staff as a result of the information. This evidence was not taken from his cell sharing risk reviews.

Question	Evidence in the cellmate’s file	Where recorded	Actions taken at Whatton
<b>Has there been any new information to link the prisoner with violent offences?</b>	The cellmate had been accused of raping another prisoner on a previous sentence and had admitted to holding another prisoner hostage with a razor blade on his current sentence.	Security Incident Reports, Security File, Adjudication Records, ACCT documents, Safeguarding Meeting minutes, Cell sharing risk assessments at Whatton.	The cellmate’s security record was discussed at the Safeguarding meeting, but no action was taken. This was picked up in the next meeting; his CSRA was reviewed to high.
<b>Has the prisoner displayed any homophobic or racist behaviour?</b>	The cellmate’s three Violence Reduction Strategy Documents were opened as a result of his interaction with other gay prisoners but there was no evidence he was homophobic. There was evidence of sexual	Violence Reduction records	The cellmate was subject to Level One or Two monitoring three times as a result of allegations of inappropriate behaviour to other homosexual prisoners. There is no evidence that this information

	harassment and anti-social behaviour.		was passed on to the sex offender treatment programme facilitators.
<b>Has the prisoner displayed any anti-social behaviour, bullying, threats, damage to property, aggression, hate-motivated behaviour, assaults?</b>	The cellmate had been accused of two serious sexual assaults against other prisoners, and was subject to Violence Reduction Strategy Documents on three occasions because of inappropriate behaviour to other prisoners.	Security Incident Reports, Security File, Adjudication records, ACCT documents, Safeguarding meeting minutes, Cell sharing risk assessments, Violence Reduction records.	The cellmate's security record was discussed at the Safeguarding meeting, but no action was taken. This was picked up in the next meeting; his CSRA was reviewed to high. He was subject to Level One monitoring three times as a result of allegations of inappropriate behaviour to other homosexual prisoners. There is no evidence that this information was passed on to the sex offender treatment programme facilitators.
<b>Is there a reason to suspect that the prisoner is abusing drugs/alcohol?</b>	When he arrived in custody, he was assessed as having substance misuse needs and it is indicated he was referred to the substance misuse team. In December 2007 the cellmate was suspected of dealing medication on the wing while just after his arrival at Whatton, In January 2008, he told staff that he had taken 20 tablets and he was no longer able to have medication in possession.	Prisoner Escort Records – including that on 5 December when transferred to Whatton, ACCT document, OASys, Security file, ACCT documents.	Recorded in Security file, in-possession medication status reviewed and ACCT opened.
<b>Does the prisoner have a history of self-harm?</b>	The cellmate was subject to nine ACCT documents while in custody on this occasion. He was described as a "prolific self-harmer" by officers at Whatton.	ACCT documents, Wing History Sheets	ACCT documents opened at time of high risk, in possession medication was revised, no evidence of input from sex offender treatment facilitators, mental health team or other healthcare staff into ACCT document.
<b>Does the security</b>	The cellmate had been accused of raping	Security File, Wing History Records	Security Information Reports were raised

<p><b>department have any information that may affect the risk assessment – eg evidence of a weapon?</b></p>	<p>another prisoner on a previous sentence and had admitted to holding another prisoner hostage with a razor blade on his current sentence. He was suspected of grooming prisoners at Wymott and his inappropriate behaviour towards other homosexual prisoners was recorded in his security file.</p>		<p>and recorded by the security department but evidence that wing staff were not aware of the serious allegations made against him. Violence Reduction Strategy Documents were opened, but no evidence that sex offender treatment programme facilitators were informed or contributed to process.</p>
<p><b>Does the Health Care team have any information that may affect the risk assessment?</b></p>	<p>No access to mental health records, although other records indicate that he had been diagnosed with schizophrenia, was taking medication that transferred with him between prisons, and was in contact with the Inreach team at the time he was taking the sex offender treatment programme.</p>	<p>OASys, Prisoner Escort Records, Sentence Management documents</p>	<p>No evidence of information sharing between the mental health team and the sex offender treatment facilitators or wing staff.</p>

208. There were several occasions when staff were concerned about the cellmate's behaviour. There was sufficient information in his records to indicate that he posed a risk to other prisoners and should not have been in a shared cell. The information was recorded, although not all staff had access to all information.
209. On 11 February 2008, a SO judged that the cellmate's risk had decreased. He described the reason for that judgement as his behaviour over the previous year. On 23 June, his cell sharing risk was reviewed and revised to low. A SO recorded that his behaviour for the preceding three years gave him no cause to believe he was a risk to other prisoners.
210. The previous CSRA system allowed decisions to be based on the behaviour of an individual, taking into account all of the relevant information. In the cellmate's case extremely risky decisions were taken at a relatively low level without reference to offender management assessments and other relevant information about risk.
211. Subsequent to this tragic killing at Whatton the guidance on cell sharing risk assessments has been revised. The new PSI 09/2011, sets out that prisoners can only be assessed as 'high' or 'standard' risk to other prisoners. It also recognises that there are circumstances when prisoners can be described as "mandatory high risk prisoners", as follows:
- Murder or manslaughter of another prisoner
  - Assisting in the suicide of another prisoner

- Committing a life threatening assault on another prisoner
- Raping or committing a serious sexual assault on an adult victim of the same sex. For Young People only (aged 15 – 17) the victim may be any age and either male or female.

212. Although it does recognise that these risks can be subject to review:

“Decisions on when it might be safe to reduce the risk rating of these prisoners to standard risk should be taken in the future based on evidenced reduction of risk in all other risk areas from offender management assessment.”

213. In the PSI, great emphasis is placed on the information available from the police national computer (PNC) and the prisoner’s adjudication history. However, those deciding whether a prisoner can safely share a cell are required to ensure that :

*“All information relevant to cell sharing risk held in NOMIS must be used to carry out initial assessments and reviews.”*

214. The cellmate had been convicted of the rape of an adult male. He would have therefore met the requirements to be considered a mandatory high risk prisoner under the new PSI. It is to be hoped that in future prisons will not reduce the risk of such prisoners lightly without full information about the risk posed. Nevertheless it is apparent that there were a series of failures in the management of his risk assessments which ultimately failed to protect the man.

**In the light of the failings at Wymott and Whatton to identify and review risk appropriately, cell sharing risk assessments at all prisons should be regularly checked by managers to ensure that they effectively identify prisoners’ risks to others.**

*Should a prisoner convicted of a sexual offence share a cell?*

215. In a letter to the then Justice Secretary, the Whatton IMB at were concerned that any prisoner who had been convicted of a sexual offence should be sharing a cell. At the time of the last inspection in 2010, sexual offending was recorded as the main offence of nearly 92 per cent of the population at Whatton. All of the prisoners were assessed as Category C or lower, so were not the highest security risk. In her meeting with the investigator, the Governor was confident that prisoners there could safely share cells, particularly with the new cell sharing risk assessment.

216. As described by the instructions set out above, a prisoner’s index offence is only part of the information that is considered when assessing their suitability to share a cell. The type of sexual offence varies greatly and so therefore does the associated risk. Those who have committed a sexual offence against a victim of the same gender will now be considered a “mandatory high risk prisoner”. However, it is not possible to determine that in all cases someone is

not safe to share a cell, solely because they have been convicted of a sexual offence.

*Should someone undertaking the SOTP share a cell?*

217. When asked whether someone undertaking the sex offender treatment programme should share a cell, the Clinical Lead of the SOTP at Whatton, explained:

“It is discouraged unless of course there is a specific reason that we would want them to share a cell, you know if they needed the extra support. The main reason it is discouraged is because, is actually less about threat to other prisoners, more about the homework and the out of session reflection that might go on and needing that private space to do those things.”

218. The cellmate asked to share a cell for additional support. His first request was turned down on 14 July, because of “recent allegations” which resulted in a VRS being opened. However, the VRS was closed on 23 July and he was subsequently moved into a dormitory on 4 August with two other prisoners. Despite having another VRS document opened on 20 August, his CSRA remained assessed as low and he continued to share a cell.
219. The Clinical Lead recognised that prisoners undertaking SOTP may get additional support from a cellmate, however, there is no record that SOTP facilitators were consulted about his request. The Clinical Lead for SOTP described “pressure points” in the SOTP course when some individuals might struggle to cope with the demands of the course. One such pressure point was when dealing with victim awareness, the stage that the cellmate had arrived at with his SOTP group. Consultation with the SOTP facilitators would have informed wing staff that he was undergoing a stressful part of the course. SOTP facilitators would also have been aware of the VRS document being opened.

*Allegations of sexual assault*

220. Two weeks after the cellmate arrived at HMP Manchester convicted of driving and other offences, he was charged with the rape of an adult male in the community. On 1 April, three and a half weeks later, another prisoner alleged that he was raped by him in the showers in December 2005, while he was there on a previous sentence.
221. An adjudication was opened, but was adjourned because the allegation had “been referred to the police for further investigation which is currently pending”. He remained on a residential wing, but was assessed as a high risk prisoner and located in a single cell awaiting the outcome of the criminal investigation. In July 2007, a year and four months after the allegation, the police concluded that there was insufficient evidence to proceed. By this time, the cellmate had been transferred to HMP Wymott. His adjudication was never revisited.

222. While police were still considering the first allegation, the cellmate was accused of holding another prisoner hostage with a razor blade and trying to make him perform a sexual act. Again, an adjudication was opened and “adjourned for police action”. The investigator has not seen a record of the adjudication, but reference is made to adjourned adjudication in his ongoing ACCT record. There is no record that the matter was referred to the police, so it has not been possible to confirm whether there was a criminal investigation following this incident. Again, his adjudication was never revisited.
223. PSO 2000 – Adjudications set out the requirements for prisons dealing with prisoners who are alleged to have offended against prison discipline. (The guidance is now in PS1 47/2011.) The PSO instructs that “any serious criminal offence ... should be reported immediately to the Governor” who will decide whether the matter is referred to the police. Regardless of that decision, a “disciplinary charge must nevertheless be made within 48 hours of the discovery of the alleged offence”. The PSO mandates that the adjudication must be adjourned “pending the outcome of the police investigation”. From the evidence available, it seems that a disciplinary charge was laid against the cellmate within 48 hours of an allegation of sexual assault both in April 2006 and in November 2006.
224. Where the police or the Crown Prosecution Service decide there is insufficient evidence to proceed to charge the prisoner with the alleged offence, and “the disciplinary charge is similar to and relies on the same evidence as the potential prosecution”, PSO 2000 instructs that “the adjudicator must dismiss the disciplinary charge”. Although there need not be a hearing for this, the PSO suggests that the prisoner must be told of the outcome of the adjudication and the adjudication record should be updated. Although the police decided not to proceed with the investigation relating to the allegations in April 2006, there was no record that the cellmate was told of the outcome of the adjudication and the record of his hearing was not updated.
225. It took the police and Crown Prosecution Service 16 months to reach a decision about the alleged rape in December 2005. PSO 2000 recognises that “unjustifiable delay” in adjudication processes could prevent a fair hearing. The order suggests, “It may therefore be necessary for the Governor or Director to press the Crown Prosecution Service for a rapid response as to the outcome of any trial or decision on their part”. From the evidence available, it is not possible to determine whether the delay in reaching a decision in this case was justifiable or otherwise, or if the Governor did press for a speedy decision.
226. There was also no formal record of the outcome of the criminal investigation relating to the first allegation. When considering the second allegation made against the cellmate, an officer recorded that the first allegation was not being pursued due to lack of evidence, but this reference is before the police have made the decision. There is also no evidence that the associated adjudication was formally dismissed. The allegation remained unresolved on his records.
227. While the incident on 1 November is well-documented in the cellmate’s files, there is almost no information about the resultant adjudication or referral to the

police. At an ACCT case review, he admitted that he was “shocked that he does not have control over the other side of his behaviour”. Despite this acknowledgement on his part, there is no evidence that the matter was referred to the police. The police liaison officer at Manchester reviewed his record at the investigator’s request and has no record of any such incident. The adjudication remained adjourned and the matter was never dealt with. The allegation remained unproven on his security file.

228. It is a matter of concern that such a serious allegation was not followed up by either a criminal investigation or a full adjudication hearing.

**The Governor of HMP Manchester should ensure that the progress of disciplinary charges which are referred to the police are monitored regularly, relevant parties including prisoners are kept informed and that the outcome is clearly recorded.**

#### *Categorisation*

229. The cellmate arrived at Manchester charged with a driving offence. He was assessed as a Category C prisoner, but by this time he was charged with raping a man. He remained at Manchester and after he was convicted of rape and sentenced on 12 April, his categorisation had to be determined again.
230. The SO, who signed off the categorisation decision, explained to the investigator that this was not a review of the cellmate’s categorisation because he was newly sentenced. If a prisoner’s categorisation is reviewed contributions from other departments, for example education and security, must be considered and it must be signed off by a governor grade member of staff. However, the initial allocation of a prisoner after sentencing requires the completion of an ICA1 form which only takes into account a prisoner’s pre-convictions, offence and length of sentence and needs to be signed off by a senior officer.
231. The first part of the ICA1 form, the provisional categorisation, which is an algorithm to determine a prisoner’s category. Officer A noted that the cellmate was charged with a sex offence, had failed to surrender and breached bail on previous occasions. There were no outstanding charges noted and he was assessed as a Category C prisoner.
232. A SO told the investigator that the ICA1 form is completed with access only to a prisoner’s pre-convictions. Security information would not normally be considered and neither would other information from the prisoner’s files. When the investigator asked whether the SO would have expected the two serious allegations of sexual assault made against the cellmate by other prisoners to be included on the form, he said he would not. The SO explained that, as neither of the charges had been proven, either by the police or through adjudication, it would have been “prejudicial” to have considered them as part of the categorisation process.

233. Manchester's Head of Residence, Governor Gregory, took a different view. He understood that it was a mandatory requirement for a prisoner's core record to be consulted when determining that prisoner's category. He said that if Officer A had been aware of the two allegations of sexual assault against prisoners, he should have taken them into consideration, despite neither allegation being proven. He said that he believed if had been aware of the facts in such a case he would have made a recommendation to upgrade.
234. The cellmate was not charged with either alleged assault by the police and had not been subject to an adjudication by the prison on the matters. The officer and senior officer had understandable concerns about prejudicing his sentence progression based on the allegations. However, the Governor's view that security intelligence needs to be considered as part of the categorisation process is appropriate and an expected part of the categorisation procedures.

**The Governor of HMP Manchester should ensure that initial categorisation decisions take into account all relevant information.**

### **Use of security information**

#### *Initial identification of risk at Whatton*

235. On arrival at Whatton both the man and his cellmate were assessed as a low risk to other prisoners despite the cellmate's PER indicating that he was a high risk and the serious allegations of sexual assault recorded on his security file.
236. Soon after his arrival on 5 December a Safeguarding Children meeting discussed the cellmate's case. The Head of Security at Whatton explained to the investigator that there were two meetings at the time, run alternately, the Safeguarding Children meeting and the Interdepartmental Risk Management Team (IRMT). Staff at either meeting should have picked up and acted on the information from his security record. The Safeguarding Children meeting that took place in December discussed the allegations made about him assaulting other prisoners, but failed to take any action. He continued to be considered a low risk to other prisoners, until the security information was reconsidered by IRMT and his risk was raised on 8 January.
237. Since 2008, the Safeguarding Children meeting and the IRMT meeting have been combined and are held fortnightly. The Head of Security told the investigator in interview that he was confident that such security information would not have been overlooked as it was in December 2007. However, he said that there was still work to do in disseminating risk information to staff on the wing.
238. The cellmate's personal officer told the investigator that he understood that he was undertaking the sex offender treatment programme and was struggling with it. He knew that he had been made subject to several violence reduction strategy documents. However, he said he did not know, and routinely would not know, the nature of his index offence. Neither was he aware that he had allegedly assaulted two prisoners while in custody at another prison. He said

that he considered such information would have been relevant when trying to manage him on the wing.

*Sex Offender Treatment Programme facilitator's knowledge of security information*

239. The Clinical Lead of the SOTP at Whatton at the time of the investigation told the investigator that she was not confident that her team would always be aware of significant security information regarding prisoners partaking in their programme. She acknowledged that some information is shared with her department from the security team, but believed that there was still room for improvement.
240. The Clinical Lead told the investigator that security information is key for SOTP facilitators to recognise behaviours that should be addressed as part of the course. She also felt that SOTP facilitators should contribute to the assessment of a prisoner's risk while they participate in the course. She explained that there are particularly difficult phases in the SOTP courses, known as "pressure points, and prisoners' behaviour can be affected at such time. They might present a higher risk.

**The Governor at HMP Whatton should ensure that the Interdepartmental Risk Management Team appropriately identifies security risks posed by individual prisoners, acts on the information without delay and that all key security and risk information is shared with those who need to know including staff delivering offender behaviour programmes.**

## **The Emergency Response**

*Responding to the cell bell*

241. OSG 2 could not specifically remember the start of his shift on 24 August. OSG 1 recalled that his colleague had carried out the roll count by 8.45pm, when he arrived for duty and reported to the central office. OSG 2 could not recall looking into the man's and his cellmate's cell, but told the investigator that he would have raised the alarm if he had seen anything suspicious.
242. OSG 2 told the investigator that it was a quiet shift. He was not called to cell B3 33 to his recollection throughout the evening. At 12.31am, the CCTV footage showed both OSGs going to cell B3 33. OSG 2 remembered being in the office at the time that the cell bell was activated. OSG 1 told the police that he had just returned from another cell, and immediately left the staff office again. He said that he did not rush to the cell. The central office where the two OSGs were based was on another floor, and OSG 2 estimated that it took them a minute to get to the cell. The footage showed both officers standing at the cell for less than a minute and then, looking through the observation panel and then walking back towards the direction they came.
243. The man's family were concerned that staff did not respond to the cellmate's cell bell quickly. The OSGs were based in the staff office. When a cell bell is

rung, staff are alerted by a light indicator and an alarm in the central office, which does not stop until a member of staff deactivates it outside the cell where the bell was activated. The OSGs made their way directly to the cell, and could be seen to spend a minute talking through the observation panel.

244. The CCTV footage gathered by the police did not cover the central office, or other areas of the wing. The footage available to the investigator showed the two officers walking directly to the cell together. During the investigation, staff demonstrated the cell bell system to the investigator. The alarm and the light were clear, persistent indicators that were difficult to ignore and there is no evidence that there was undue delay in responding to the bell.

#### *Opening the cell*

245. PSO 2710 – follow up to deaths in custody, advises that, “if the apparent death has taken place in a cell, the first person on scene must enter the cell as soon as possible”.
246. According to their statements, the cellmate did not tell the OSGs what he had done when he first called them to the cell, but said that he needed to see the night orderly officer. (He did not make any comment in his statement to the police.) Four minutes after the OSGs left the cell, OSG 1 walked back to the cell and spoke through the observation panel. It was at this point (he told the police) that the cellmate said that he had killed his cellmate. The NOO arrived at the cell five minutes after he made this statement.
247. According to the National Security Framework (since overtaken by PSI 24/2011):

‘Under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two/three (subject to local risk assessment procedures) members of staff are present one of whom should be the NOO.’

Guidance to staff clarifies that:

‘Staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over the directions.... above. Where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO (but subject to the conditions set out in 5.19 below) and an individual member of staff may enter the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.’

248. The NOO said that she was in the security department when she received a telephone call from the Communications Room. She said she was initially advised that a prisoner was hearing voices and she was required to attend. She recalled receiving a second telephone call, advising her that the situation

was urgent and she needed to get to B wing quickly. She asked her assistant NOO to accompany her and they “proceeded with haste” to B wing. She told the investigator that staff are “not allowed to run”, possibly for health and safety reasons. In the meantime, OSG 1 had remained with the cellmate since he said he had killed his cellmate. At the time he described him as ‘still on edge but his body seemed quite relaxed. There was no anger in him at all’.

249. Once she arrived on the wing, the NOO and her assistant joined OSG 1 at the observation panel. The NOO spoke to the cellmate through the panel. She recalled that he was “pacing” and “quite frightening”. The officers and OSG stayed at the cell for a minute and then the observation panel was closed and they all left them alone in the cell.
250. Over the next eight minutes, the NOO went to another wing to collect two officers. She said she had to ensure that she had sufficient staff to meet the requirements of the local security strategy before the cell could be opened at night. She explained that, although there were already four members of staff at the cell when she first arrived on the wing, two were OSGs, who she described as “non operational”. She said:

“ ... they’re not supposed to have prisoner contact. Normally they’ll just be patrolling and wouldn’t actually come into contact with prisoners, other than perhaps through a cell door ...’

251. The local security strategy does not specify the grades required to attend a cell at night, before it can be unlocked. The requirements of an OSG are set out in PSI 42/1997. While they are not strictly non-prisoner contact roles, they are not routinely trained in Control and Restraint, the techniques used to physically manage fractious or violent prisoners, when the situation cannot be de-escalated through verbal reasoning. Nevertheless contrary to what the OSGs said all such staff at night are issued with cell keys in a sealed pouch to open a cell door in an emergency. It is a matter of concern that the OSGs appeared not to be aware of this.
252. The NOO had to judge whether the situation was sufficiently serious as to require officers trained to handle a violent prisoner. The cellmate had claimed to kill his cellmate. He was in a shared cell. All of the officers and OSGs told police or the investigation team that they did not have a clear enough view to determine the man’s condition. The NOO could not have reasonably ruled out the possibility that the man and his cellmate posed a threat to the security of the prison. It is reasonable that she sought assistance from other officers in the prison who were trained to deal with potentially dangerous prisoners.

*Leaving the cell unattended*

253. From the moment staff left, until the orderly officer returned eight minutes later, the cell was checked twice, once for thirty seconds and once for two seconds. The rest of the time, the cellmate and the man were left alone. When asked by the investigator whether she had asked anyone to remain at the cell, the NOO said:

“I think so, yes, but I can’t be 100% sure; but I am pretty sure that that would have been the case, yes.”

254. The assistant NOO told the police that he remained at the cell talking to the cellmate while the NOO left the wing. When the investigator asked him whether he remained with him during that time, he responded:

“And I can’t exactly remember whether I stayed. I thought I’d stayed with him, talking to him all the time. But if the CCTV footage shows I didn’t, I didn’t.”

255. Incidents like this are extremely rare and there is a scarcity of guidance to staff determining how they should respond. Although there are no requirements or instructions, staff should have remained with the cellmate while the NOO left the wing. While it was reasonable to delay opening the cell until more appropriately trained staff were present, his claims were of such a serious nature that ongoing monitoring was necessary, to determine the veracity of the claims and manage any possible risk to safety or security.

*Emergency response for the man*

256. The NOO had ensured that sufficient staff were available to open the cell safely. On leaving the cell the cellmate was compliant and did not pose any threat and control and restraint techniques were not required. Nevertheless, it took nearly two minutes after that for the assistant NOO to enter the cell and check the man’s vital signs. He was alone at the cell when he entered. On the CCTV footage, he clearly leans against the door for some time before finally going into the cell. He explained why he did not go straight into the cell:

“I was like shouting his name and I was seeing if he’d respond. I didn’t know whether he was going to still jump up or what; I don’t know why I had that fixed in my mind. I just thought they’re messing about, I really did think they were messing about.”

257. When asked during interview why staff did not go into the cell as soon as the door was opened, the NOO explained:

“From memory everything was dealt with as quickly as possible. But we just wanted to get the cellmate out of that cell and out of that environment so the man could be tended to due to the state of [the cellmate’s] mind and his demeanour.”

258. Despite his concern for security, the assistant NOO was not accompanied by anyone when going into the cell and there was no one outside to assist him. Neither did he enter the cell straight away to check the man’s vital signs and begin resuscitation. None of the team that had gathered to open the cell safely remained with him to manage the possible security risk or assist with the emergency as it unfolded. As a result, valuable minutes were lost before the man’s condition was confirmed and resuscitation begun. It is important for such

emergencies that there are always first aid trained staff on duty at night and the Governor of Whatton has assured us that to ensure this is the case all night orderly officers are first aid trained and that this was the case in 2008.

259. An ambulance was called once the assistant NOO had started resuscitation efforts. The NOO explained that she did not request an ambulance earlier than that because “we still had to rule out that it wasn’t a decoy or a hostage situation”. The senior officer told the investigator that to call an ambulance earlier could have undermined “the safety of the prisoners in the cell, the safety of staff, and the security of the prison in general”. She said that she wanted to be absolutely “clear of the situation and what I was dealing with to relay a message to the Ambulance Service as to why they need to come in”.
260. The Prison Service and the Health Service have subsequently reinforced the guidance in such situations. In a letter written jointly to all prison Governors and Primary Care Trusts by the Director of Offender Health and the Director of NOMS, dated 17 February 2011:

“Where there are concerns about the immediate health of a prisoner an ambulance should be called without waiting for healthcare staff to attend the scene. A follow up call can be made to cancel the request if healthcare arrive and deem it unnecessary for an ambulance to respond.”

261. The NOO was also under pressure because of the number of staff on duty at night at Whatton. To have arranged for an ambulance to be effectively accompanied from the entrance of the prison to B wing would have taken at least one or two staff, and she required several to attend the cell before it could be opened.
262. Nevertheless, an ambulance should have been called as soon as the man’s health was in doubt. Despite there not being complete clarity about the situation the NOO, or any other member of staff on duty, should have judged an ambulance was needed as soon as the nature of the emergency became apparent.

**The Governor of HMP Whatton should ensure that all grades of staff working at night understand the night procedures and their respective responsibilities in an emergency including the need for constant monitoring of emergency situations and the need to call an ambulance immediately if there are urgent concerns about a prisoner’s health.**

*Measures for the cellmate*

263. When the cell was finally opened, the cellmate was brought out of the cell, searched and then relocated to another, empty cell. The NOO explained that she and an officer removed all of the obvious ligature points from the cell because, “if someone’s capable of doing something like that, then you’ve got to question their state of mind”. Once he was in the cell, an officer was stationed outside to monitor him.

264. The Duty Governor requested that the cellmate was moved to the segregation unit. From here he was taken by police into their custody for questioning. Ultimately, he was moved into the Close Supervision Centre, at HMP Woodhill, a national resource used to manage the most disruptive prisoners. The management of his risk on that evening was appropriate.

### **Night time staffing levels at Whatton and on B wing**

265. The man's family were concerned that the cellmate's supervision was compromised by low staffing levels on B wing. The investigator reviewed CCTV footage of the landing on the afternoon of the incident. Staff were visible on the landing and could be seen interacting with prisoners, but the Inspectorate commented in the 2007 report that staff did not always patrol landings during association. There was also some concern in 2007 that there had been an influx of new staff, many of whom had never previously worked with sex offenders and lacked understanding of working with sex offenders and the need to support treatment interventions. In the 2010 inspection they found better levels of engagement and that staff interaction on B wing was particularly good. None of the prisoners interviewed by police suggested that staff were insufficiently present on the wing to pick up on the cellmate's comments that afternoon. Instead, they suggested that he spoke to other prisoners only.

266. The Head of Security at Whatton explained that staffing levels were risk assessed, although it was not his responsibility to carry out the risk assessment. When the investigator fed back to the Governor about the family's concern about staffing, she was confident that the staffing levels met the minimum requirement and the needs of the prison population.

267. When asking for further information about staffing levels on B wing, the investigator was provided with a document entitled, "HMP Whatton Placement of Night Staff", dated 7 September 2011. The document recorded that there were 12 Operational Support Grades on the wings at night, and a minimum of four officers in the prison. B wing was required to have a minimum of one officer and one OSG, although according to a note at the end of the document, "B wing has a minimum of an OSG and an Officer and any spare staff are allocated to this wing by the [Night Orderly Officer – responsible for managing the prison]. At the time of the man's death there were only two OSGs on B wing and we were informed that the increase to include officer presence was as a direct result of his death.

268. The Governor is confident that her staffing levels meet the minimum requirement set out by NOMS. However, it is a matter of concern that on the night of the incident the orderly officer had to choose between managing the threat that the cellmate posed to security and calling an ambulance to preserve the man's life.

269. It was not clear from the records whether the cellmate was transferred directly from the segregation unit (where he was held following the serious sexual assault on another prisoner on 1 November 2006), or whether he was

transferred from the healthcare centre at Manchester. The significance of these details are heightened by the apparent aberration in the cell sharing risk assessment when he arrived at Wymott.

### **Family liaison**

270. The annex to PSO 2710 – follow up to deaths in custody outlines guidance for family liaison in the event of a death in custody. This guidance suggests that “face to face notification is best” and “notification by the prison is best”. The news of the man’s death was broken to his family by the police. Given the extremely rare event of a homicide in prison, and the role of the police in the subsequent investigation, it was appropriate for them to take the leading role in family liaison. When the investigator and family liaison officer from this office met the family, they had no complaint about the liaison from the prison. They recalled that the Governor had visited them following his death. They had no complaints about the prison’s dealings with them. The family understood why the police took the leading role in family liaison, given the criminal investigation.

## CONCLUSION

271. The cellmate had allegedly sexually assaulted prisoners on two previous occasions. He had been convicted of the rape of an adult male two years before the man's death. There were concerns that he was 'grooming' other prisoners at Wymott. He was the subject of three Violence Reduction Strategy documents, due to his inappropriate behaviour to other prisoners at Whatton, the last of which was open at the time he murdered the man. Given the security information available in his files, he should have been considered a risk to other prisoners and not been sharing a cell. The lack of action on these indicators of risk meant that there was a failure to protect the man.
272. At Manchester prison the cellmate was considered such a risk that he was held separately in the segregation unit yet he was categorised as C and sent to Wymott. At Wymott where he was considered too risky to go to the vulnerable prisoner side of the prison where most sex offenders are held and could not therefore take part in the sex offender treatment programme. Despite this concern unaccountably his cell sharing risk assessment was reduced at Wymott. Even more concerning is that Wymott then transferred him to Whatton a category C prisoners for sex offenders. It is inexplicable why he was considered suitable for Whatton when Wymott regarded him as too high a risk to live with other sex offenders there. At no stage does anyone seem to have considered whether he was appropriately categorised. When he transferred from Wymott his PER indicated that he was a high risk for cell sharing.
273. Despite this information the cellmate was assessed as a low risk in August 2008. Under the new cell sharing risk assessment procedures, he would have been considered a "mandatory high risk prisoner" which indicates there has been some change since the man's death, although most of the failures in this case were the result of practice rather than poor guidance. Lessons should be learned in the effective communication of security information to inform the management of risky prisoners and to ensure that such information is acted on.
274. In the early hours of 25 August, staff responded quickly to the cellmate's initial emergency call. However, too much time elapsed before the cell was opened and the man's condition was assessed and the emergency services called. Homicides in prison are thankfully rare, but the preservation of life in any emergency should be a priority.

## RECOMMENDATIONS

### National Recommendation

1. In the light of the failings at Wymott and Whatton to identify and review risk appropriately, cell sharing risk assessments at all prisons should be regularly checked by managers to ensure that they effectively identify prisoners' risks to others.

**Accepted.** Response as follows:

Governors and Directors of prisons have been instructed to use the guidance detailed in PSI 09/2011 'Cell Sharing Risk Assessment', reinforced in PSI 64/2011 'Safer Custody', with regards to CSRA policy.

Within PSI 09/2011 it states that all CSRA reviews must be carried out by, or subsequently approved by, a multi-disciplinary team to ensure that a balanced and reasonable risk decision is taken. The authorisation section of the CSRA should be signed by the chair of the multi-disciplinary team or the Duty Governor or Manager.

### Recommendations to HMP Wymott and HMP Whatton

2. The Governors of HMP Wymott and HMP Whatton should ensure that all initial cell sharing risk assessments are based on information contained in a person escort record (PER) and security and other information available at the time of a prisoner's arrival.

**Accepted.** Response as follows:

#### HMP Wymott

All prisoners on arrival in Wymott have their Cell sharing risk assessment reviewed in line with PSI 09/2011 Section 6.

#### HMP Whatton

Reception CSRA procedures changed with the introduction of PSI 09/2011. It is now the responsibility of the sending prison to complete a full CSRA. Local procedures at HMP Whatton are that if any prisoner is transferred in using the old format CSRA then a new one is completed immediately in reception with the available information. The safer custody team provide a quality check of all CSRAs within a week of reception and scan onto the shared electronic drive.

### Recommendations to HMP Whatton

3. The Governor of HMP Whatton should ensure that staff review cell sharing risk assessments when a VRS document is opened.

**Partially Accepted.** Response as follows:

CSRA reviews are conducted in accordance with national guidelines as per PSI 09/2011.

4. The Governor at HMP Whatton should ensure that the Interdepartmental Risk Management Team appropriately identifies security risks posed by individual prisoners, acts on the information without delay and that all key security and risk information is shared with those who need to know including staff delivering offender behaviour programmes.

**Accepted.** Response as follows:

Risk information identified by IRMT is circulated appropriately and the prisoner Prison-NOMIS record is flagged accordingly.

HMP Whatton maintains an electronic current concern board that is brought to the attention of all staff. This holds the prisoner image, recent behaviour and security concerns.

5. The Governor of HMP Whatton should ensure that all grades of staff working at night understand the night procedures and their respective responsibilities in an emergency including the need for constant monitoring of emergency situations and the need to call an ambulance immediately if there are urgent concerns about a prisoner's health.

**Accepted.** Response as follows:

Night staff are fully aware of night procedures and their responsibilities including what action to take to summon an ambulance.

### **Recommendations to HMP Manchester**

6. The Governor of HMP Manchester should ensure that the progress of disciplinary charges which are referred to the police are monitored regularly, relevant parties including prisoners are kept informed and that the outcome is clearly recorded.

**Accepted.** Response as follows:

The process by which disciplinary charges are referred to the police is monitored and relevant parties are kept informed will be reviewed and updated accordingly.

7. The Governor of HMP Manchester should ensure that initial categorisation decisions take into account all relevant information.

**Accepted.** Response as follows:

All initial categorisations decisions take into account all relevant information.