Investigation into the circumstances surrounding the death of a man at HMP Peterborough in September 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Peterborough in September 2008. He was found collapsed and dying in his cell shortly before 9.00pm that day. Attempts at resuscitation by prison staff and paramedics failed to save his life.

I extend my condolences to the man's family and all those touched by his death. I am grateful to staff at HMP Peterborough for their assistance during my investigation.

Following post mortem examination, a consultant pathologist found evidence of blunt force injuries to the man's head and face (as well as to other parts of the body). The pathologist also found that the man had pre-existing ischaemic heart disease. The pathologist concluded that the most likely explanation was that the stress of an assault had precipitated a fatal cardiac dysrthythmia in the face of significant underlying heart disease.

Cambridgeshire Constabulary identified six prisoners whom they considered to have been involved in a concerted assault on the man. One of the six admitted his involvement and pleaded guilty to a charge of manslaughter. The other five denied involvement and were put on trial, also for manslaughter. At Crown Court on 23 December 2009, three of the co-defendants were acquitted, while two were found guilty.

The Prisons and Probation Ombudsman's investigation was suspended pending the criminal investigation and proceedings. At the conclusion of the criminal proceedings, one of my colleagues carried out an investigation for this office. His investigation focused on events prior to the man's death, in particular, whether sufficient action was taken in response to information suggesting that he might have been at risk from other prisoners.

I apologise for the delay in issuing my report and for any additional distress this may have caused.

I make five recommendations. Two relate to the way staff record and address inappropriate and potentially violent behaviour. One is about taking account of security information when allocating prison jobs. Another is about dealing with prisoners who might be involved in the buying and selling of goods. The last is about the need to conduct an audit of the cell alarm system.

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

Thea Walton
Deputy Ombudsman **October 2011**

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SUMMARY

1. The man was 33 years old, dying in unusual circumstances in HMP Peterborough in September 2008. His cause of death was blunt force injury to his head and face in association with underlying ischaemic heart disease.

2. The event that precipitated the man's death was an assault made upon him while in his cell. Several prisoners were arrested and initially charged with murder. These charges were later reduced to manslaughter following the post mortem examination. The pathologist's findings included evidence of blows to the man's face, head and torso, but the injuries were not so serious as would ordinarily result in death. The pathologist also found that the man had an underlying heart condition and that the stress of the assault caused cardiac arrest. At court, three prisoners were convicted of manslaughter. The jury accepted that it had not been their intention to take the man's life, but had instead intended to issue him a "violent warning".

3. This investigation has found no evidence indicating that either the man, his friends or staff realised that other prisoners were planning an assault. However, there was evidence that the man was alienating some of the other prisoners through some of his behaviour. This evidence was captured in security information reports, but little action was taken to deal with what might be considered a 'pattern' of unacceptable behaviour.

4. An unfortunate aspect of the events occurring on the evening of the man's death was that when the other prisoners launched their assault, the man pressed his cell alarm, as did a friend of his who was in the cell at the time. Unfortunately, the alarm failed to activate; seemingly through an unexplained technical problem. Part of the pathologist's evidence, however, was that even with early medical intervention his chances of survival would still have been very poor.

5. My report focuses on potential learning for Peterborough. The direct cause of the man's death was established during the criminal trial following his death. I make five recommendations. Four of these relate to the management of prisoners who engage in violent behaviour or in the buying and selling of goods. The other relates to the prison's cell bell system.

INVESTIGATION PROCESS

6. Following the man's death my office made contact with HMP Peterborough and also made contact with the Cambridgeshire Constabulary. The police provided copies of CCTV recordings from the prison wing and also copies of witness statements. In adherence to a protocol existing between my office and the Association of Chief Police Officers, this office agreed to suspend its investigation pending the outcome of the police investigation. .

7. Upon the conviction of three prisoners charged with involvement in the events leading to the man's death, one of my investigators attended a meeting with the Cambridgeshire Constabulary to further discuss the evidence they had collected. The investigator also visited HMP Peterborough to see the man's cell and to observe the wing. The investigator obtained an explanation about the operation of the cell alarm system. The investigator explained the extent and scope of the Ombudsman's investigation.

8. The investigator subsequently interviewed six members of staff and spoke to nine prisoners. One of the prisoners was a friend of the man's who was in his cell at the time he was assaulted.

9. The investigator contacted the Coroner, to whom a copy of this report will be sent. However, there will be no inquest into the man's death as the circumstances directly leading to his death have already been considered at Crown Court.

10. My Senior Family Liaison Officer wrote to the man's wife, father and two ex-partners to explain about the Ombudsman's investigation. The family were interested in receiving a copy of my report but did not raise any particular issues that they wanted to be considered during this investigation. I hope that my report offers further explanation into the events leading up to his death.

HMP PETERBOROUGH

11. HMP Peterborough is a privately run prison, operated by Kalyx, under a 25 year contract to the Home Office. Opened in March 2005, it is the country's only purpose-built prison for men and women, who are kept separate at all times.

12. The operational capacity for male residence is 480. There are eight wings on the male side radiating from a central hub and cellular accommodation comprises both single and double cells. The residential area is on two levels.

13. Her Majesty's Chief Inspector of Prisons conducted a short follow-up inspection of Peterborough in June/July 2008. Following the previous inspection, the Chief Inspector made a recommendation about the need for improvements in the process for investigations into allegations of bullying. In considering the action taken by Peterborough the Chief Inspector wrote in the follow-up report that:

> "A violence reduction referral form was usually completed following [an incident] and prisoners were placed on the first stage of the violence reduction strategy. The high number of prisoners automatically placed on the strategy risked masking the extent and focus on bullying and did not sufficiently distinguish behaviours … Few investigations included supporting statements from victims. There were often delays between the incident, investigation and subsequent action taken … Delays could result in staff and victims losing confidence in the system. No prisoners were currently [being] monitored through the violence reduction strategy, which was unlikely to reflect the true situation …
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> "There were no effective interventions for bullies. Plans to introduce … a course for prisoners with challenging behaviour had not materialised ... Weekly reviews were held for any prisoner monitored as a suspected bully, but the records did not suggest there had been any real challenge about bullying behaviour. Only eight prisoners had been placed on stage two [of the violence reduction strategy] in 2008.
>
> "There was no evidence that bullying was a major problem or that the prison was generally unsafe ... although [when compared to the last review] there was now a better analysis of indicators of violence, there were some discrepancies between sources including the number of prisoner on prisoner assaults recorded through the incident reporting system and through the violence reduction database."

14. Peterborough's anti-bullying policy comprises three stages. Stage 1 can be instigated if any member of staff who witnesses any inappropriate anti-social behaviour. The prisoner will suffer no loss of rights or privileges but their behaviour will be monitored for between seven to 28 days. A prisoner will be placed on to stage 2 if found guilty at an adjudication of fighting or committing an assault or if is where there is a clear pattern of anti-social behaviour. In this case the prisoner is likely to lose for a time some of his rights and

privileges and the prison will implement a plan to help him address his inappropriate behaviour. Moving a prisoner to stage 3 of the procedure will be considered in the case of some combination of behaviours such as repeated intimidation, continued aggression or a failure to respond to stage 2. Sanctions in this case include a reduction in entitlement to privileges and consideration of moving the prisoner to the segregation unit.

15. My office took over responsibility for investigating deaths in prison custody in 2004. Since that time there had been only three deaths of male prisoners before that of the man's. All three prisoners died from natural causes and no issues arose during the investigations of those cases that were relevant to the circumstances surrounding his death.

KEY EVENTS

16. The man was born in March 1975. He had one brother. He spent most of his working life as a taxi driver but later established a chauffering firm.

17. On 12 October 2007, the man was remanded into HMP Woodhill near Milton Keynes, having been charged on a count of grievous bodily harm and a number of linked offences.

18. During a standard first reception health screening assessment at Woodhill, the man was asked whether he suffered with a number of specific illnesses, including heart problems or chest pain. He denied having any of the listed conditions and when asked if he had any other concerns about his physical health, replied that he had none.

19. On 17 October, he transferred to HMP Peterborough and later that month was convicted of the offences with which he had been charged. He was subsequently sentenced to four years imprisonment.

20. Having completed the reception and induction processes, the man was initially allocated to a cell on Y2 wing.

21. The Prison Service uses a variety of forms to record the large amount of information that is collected about prisoners. One of the forms is the F2052A form, which is commonly referred to as the "record of events" or "history sheet". This is the document used to note much of a prisoner's day to day activity. Entries made in the man's history sheet during his first weeks in Peterborough were positive, although one entry made at the end of November included the comment that he "can still be a drain on staff at times but behaves well." That same entry also reported that he started working as a wing cleaner that day.

22. Further entries in the man's history sheet during December and early January 2008 again reflected that he was working well and was complying with the prison's regime.

23. All prisons have a system for dealing with any information or intelligence that might affect the security of the prison, the security of its staff or the security of prisoners. Any member of staff who identifies any matter that might compromise safety should complete a security information report (SIR). The SIR is then passed to the prison's security team. The security team will rate the information received in order to assess various matters such as the reliability of the information, the potential risks and the action that should be taken. On 14 January 2008, a member of staff wrote an SIR after witnessing a suspicious incident where two prisoners appeared to exchange an item which they each took pains to conceal. The prisoners involved were the man and one of the prisoners later involved in the assault on him. This information was not copied into his history sheet. Nor was it copied into the wing observation book (in which observations about individual prisoners or general comments about the wing might be recorded).

24. At some time in January, the man stopped working as a wing cleaner and instead became a servery worker (which meant that he gave out food at meal times). An entry in his history sheet made on 27 January referred to him having an argument with another of the servery workers about the running of the servery. The man changed jobs a few days later, this time taking the role of a Connexions worker. (This entails helping other prisoners with paperwork relating to housing problems and other social issues.) Nothing is recorded about whether it was the argument with the other prisoner that led to him changing jobs.

25. As with all prisons, Peterborough operates an Incentives and Earned Privileges (IEP) scheme. (Prison IEP schemes aim to encourage and reward responsible behaviour through the award of greater privileges where a prisoner has been compliant with the prison regime and has engaged in work or other constructive activity. Enhanced status is the highest level within the scheme.) Five separate entries in his history sheet through January all refer positively to the man's behaviour. He was noted to be polite to staff and prisoners and compliant with the regime. As a result, an application was put forward for him to be raised to enhanced status within Peterborough's IEP scheme. The wing officer's comments in support of his application said that: "[This man] is a good worker … a trusted worker who is polite to staff and mixes well with other prisoners." He was raised to enhanced status.

26. Positive entries about the man's behaviour continued to be made in his history sheet through the month of March, during which time he moved to Z2 wing. A few days later an officer submitted an SIR to say that he overheard the man call out to another prisoner asking for a message to be passed to a third prisoner reminding him that if he did not repay a certain debt he would "get a smack". The report was noted with the action to be taken: that wing managers were to be advised of the incident and that the man was to be monitored for three days. This information was not included in the man's history sheet, nor was it included in the wing observation book.

27. On 5 April, the man's history sheet was noted to say that he had settled well onto Z2 wing. Later on in the month, an officer recorded some apparent concern for the man as it seems he was thought to be too quiet. The officer noted asking him if he had "any issues" to which he answered that he had none.

28. On 21 May, an officer submitted an SIR after a prisoner told him that the man was threatening another prisoner and attempting to take items from that prisoner. The officer added into his report that he had seen no evidence to substantiate the allegation, and the prisoner who made the allegation was not willing to say anything further. Again, this information was not included in his history sheet, nor in the wing observation book.

29. A week later, the man was involved in an altercation with another prisoner. It would seem that an argument arose following a misunderstanding about the lending and borrowing of a computer game console. The man would seem to

have exchanged blows with the other prisoner, although neither was injured. When questioned, each blamed the other for the misunderstanding. Later on that day, the man showed an officer a note that had been pushed under his door that said "you're a dead man". Also on that day, the prisoner with whom he had had a fight, told staff that he had been bullying servery workers for extra food.

30. Peterborough's response to the incident was to move the man to X2 wing and to monitor him for a period of time under the local anti-bullying procedures. Before he moved to his new wing, two prisoners told an officer that it was not wise for the man to remain on Z2 wing as there was "bad feeling towards him on the wing".

31. The only entry made in the man's history sheet about the events of these few days was one referring to the confrontation with the other prisoner and that anti-bullying paperwork had been started.

32. Two more reports about the man were submitted on 2 June. In a Violence Reduction Referral Form, a prisoner was noted to have reported the man asking him to pass a message to the prisoner with whom he had had a fight. The message was that if the other prisoner "wants to call it quits and shake hands then all will be left but if I get in trouble for hitting him he's …dead".

33. The other report was an SIR raised when a prisoner who claimed he was being bullied by the man who thought him a "grass", was arranging for the man to be "sorted out".

34. Both of the reports were considered under Peterborough's violence reduction measures. It was decided that no further action needed to be taken for the moment as the man had been transferred to a different wing and he was being monitored under stage 1 of the local anti-bullying procedure. A note was made that if any further incidents were to arise, that the man would be raised to stage 2 of the anti-bullying procedure. Neither of the two incidents of 2 June were recorded in the man's "history sheet".

35. Monitoring of the man's behaviour continued from 5 June to 12 June when it ceased as no further concerns or incidents had arisen in that time

36. The man consulted one of Peterborough's doctors on 19 June complaining about chest pains. On examination, the doctor detected no sign of chest wheezes. The doctor measured the man's "peak flow" (his ability to blow air from his lungs, a way of diagnosing asthma). The doctor recorded that the had achieved a "perfect score" and that he had no history of asthma.

37. Also in June, the man failed a mandatory drug test, showing that he had taken an opiate based drug. He was tested periodically for presence of drugs in his system and it seems that this was the only occasion that he failed a test.

38. Another SIR made on 10 July indicates that the man was making threats to a prisoner on another wing about unpaid debts. No mention of this incident was recorded on the man's history sheet nor in the wing observation book.

39. The man started a new job as the principal servery worker on X wing on 14 July. An entry in his records this day said "… works well, no issues from him. Compliant with officers and regime".

40. On 23 July, the prisoner with whom the man had had a fight in May complained that the man was regularly sending him threatening messages. The prisoner said that although he was on a different wing, he was avoiding going to the gym or anywhere else where he might encounter the man. Consideration was given to placing the man on "stage 2" of the anti-bullying procedure although it does not seem that this actually happened. No mention of the incident was recorded in the man's history sheet, nor in the wing observation book.

41. Two entries in the man's history sheet in early August each contained both positive and negative comments. The positive comments were about him being a hard worker who was polite to staff and generally compliant with the prison regime. The negative comments included reference to him having an "issue" with another prisoner (no detail was included about this "issue") and that he needed to be reminded about maintaining the boundaries between officers and prisoners.

42. On 13 August an officer on X2 wing submitted a SIR about the man which said:

> "[The man] seems to believe that he has the right to question officers' judgement. He seems to feel superior and is using his size/reputation to intimidate staff/inmates."

43. The officer who wrote the above report also made an entry in the man's "history sheet" to say:

> "Has had an issue with myself. Interfering with wing discipline. It seems the line between officer and prisoner is "blurred" with [the man]."

44. On the same day, another prisoner complained to staff about the man. He said that he was stealing from the servery by giving out "short servings". The prisoner also complained that he was intimidating smaller/younger prisoners. The security information form on which this incident was recorded was noted to say that there had been previous complaints about the man threatening and intimidating other prisoners. The planned action for dealing with the matter was to inform the wing managers and for him to be interviewed (there is no evidence that this happened).

45. A positive entry made about the man in his "history sheet" on 17 August said:

> "No issues, polite to staff and compliant with regime. Good [principal worker] in servery, keeps it moving very quickly, always knows what's going on."

46. Two days later a prisoner complained that the man became confrontational about the music he was playing. This information was recorded in both a security information report and in the man's "history sheet".

47. An entry made in the man's records on 8 September was positive. It referred to him being in good spirits, that he was working well in his job and was compliant with the regime.

48. A prison custody officer (PCO) told my investigator that he first met the man on Z wing not long after he first arrived at the prison. The PCO said that the man tended to keep himself to himself, but he seemed "more or less happy". Referring to the man's then role as a Connexions worker, the PCO said that prisoners selected for this work will be those with a good grasp of spoken and written English and who relate well to others. The PCO later transferred to X wing and the man followed around two months later.

49. The PCO said that when he encountered the man again, this time on X wing, he seemed much the same as he had been previously. He was by then working as the principal servery worker. The PCO said that the man kept the servery clean and he was quick and efficient at serving meals. No prisoners complained about him as far as the PCO was aware. The PCO explained that an officer always supervises the serving of meals. This means that any issues about matters such as prisoners trying to jump the queue, or asking for extra portions is handled by the officer and not by the servery workers. He added that the man got on well with the other servery workers and they tended to go to the gym together. Indeed, he seemed to get on with most of the other prisoners and the PCO was unaware of any prisoner on the wing being resentful of him. My investigator asked the PCO if he knew what was meant by the entry in the man's records made in August about him needing reminding of the boundaries between officers and prisoners. The PCO said that the man was very friendly but he needed to be reminded to be not so familiar. He added that the man was not unique in behaving this way as most prison wings had a prisoner who tended to blur boundaries.

50. Another PCO also first met the man when he was on Z wing. She told my investigator that she always found the man to be a polite and compliant prisoner. She told my investigator how the serving of meals is arranged. She explained that every prisoner would have previously submitted their menu options and their choices read out when they reach the servery. Officers, however, are responsible for supervision of the process.

51. She told my investigator about an incident that occurred during the serving of the evening meal on the day of the man's death. He was working as the principal servery worker as usual. One of the prisoners who was involved in the later attack on him tried to push to the front of the queue. She stepped forward and told him to go to the back of the queue and wait his turn. She

had to repeat the instruction before the prisoner complied. She said that while she was speaking to the prisoner, the man did not say anything, he just went on with serving the meals.

Events on the evening of 11 September

52. Three PCOs were on duty on X2 wing during evening association on 11 September. CCTV footage from just before 7.50pm shows a prisoner from the upper landing walking down one of the two stairways leading to the lower landing. This was the stairway at the end of the landing furthest away from the man's cell. When the prisoner reached the bottom of the stairs, he collapsed, apparently suffering an epileptic fit. The first PCO was on the lower landing closest to where the prisoner collapsed and she went to assist him.

53. The first PCO told my investigator that she was dealing with paperwork in the wing office when she was alerted by a prisoner that another prisoner had collapsed to the floor. She went over to the collapsed prisoner and noted that he was breathing, but thought that he should be checked by a nurse. She had not been issued with a radio that evening as she was mainly dealing with paperwork. The second PCO was at the other end of the lower landing and she called out to him to contact healthcare.

54. The first PCO said that the two other PCOs came to the collapsed prisoner while she radioed healthcare. A nurse arrived on the wing and began treating the collapsed prisoner. At that point, the first PCO went back to the wing office to continue with her paperwork and the other officers resumed patrolling the wing.

55. The first and second PCOs' evidence to my investigator was consistent.

56. My investigator was not able to speak to the third PCO as he has since left the employment of Kalyx (the private company that runs HMP Peterborough). His movements, however, were captured on CCTV. The footage shows that he was on the upper landing when the prisoner collapsed on the opposite lower landing. It would not seem that he realised at first what had happened. It seems, instead, that it was when the first PCO began moving towards the collapsed prisoner that he thought there might be an incident occurring where his help was needed. At that point, he walked down the stairs and towards the opposite end of the lower landing. This left the upper landing unstaffed.

57. Meanwhile, the CCTV footage shows several prisoners from the upper landing leaning over the banister rails. At the point that all three of the PCOs are attending to the collapsed prisoner, four of the prisoners from the upper landing enter the man's cell. One of the four leaves very soon after entering, but the other three remain in the cell for several minutes. (Another prisoner, a friend of the man's, was in the cell when the other prisoners entered and he remained in the cell throughout the time that they were in the cell.)

58. At around 8.10pm staff began to lock-up prisoners for the night. The second PCO was locking the upper landing. He told my investigator that one of the duties of the principal servery worker is to prepare the meal total sheets for the following day stating how many of each menu item is needed from the kitchen for the wing. He said that the man was well organised and was usually ready to pass over the sheets at lock-up time. This evening was different as he was not standing by his door as usual. The second PCO said that he pushed open the door and saw that the cell was in disarray. He said that this also was unusual as the man kept his cell in well ordered condition. He saw him slumped on the floor in a sitting position with his back against the wall. He tried unsuccessfully to rouse him and then radioed for an emergency medical response. He said that the third PCO came into the cell and they both tried to find a pulse, but without success. He said that more staff began to come into the cell at this point and he found himself being pushed away from him.

59. A Senior Prison Custody Officer (SPCO) and another PCO arrived together at the cell and both wrote statements about their involvement. Both report that at the time of their arrival the man was in a seated position slumped against the wall. The SPCO noticed some liquid coming from his mouth and, worried that he might choke, moved him into the 'recovery position' (a lying position on the side). She checked him for signs that he was breathing and, finding that he was not, instructed her colleagues to move him onto his back. She checked once more for signs of breathing. There were still no signs and at that point staff started cardio pulmonary resuscitation (CPR).

60. A nurse arrived and she checked the man with a defibrillator[1], which advised that no shock be given but that efforts at CPR should continue. Staff continued their efforts at CPR until ambulance paramedics arrived and took over. Unfortunately, all attempts to revive the man proved unsuccessful and he was pronounced dead at just before 9.00pm.

61. Most of the officers who entered the man's cell noticed that there was a great deal of mess, one officer described the cell as "trashed". This was particularly striking for the staff as the man was known for keeping his cell clean and in good order. The second PCO had noticed some bumps and bruises on the man's face and the third PCO told the SPCO that he thought the man had been beaten.

62. The local police force is routinely informed without delay about a death in prison custody. The police will visit the prison and examine the scene where the death occurred. In the vast majority of cases, there will be no evidence of foul play or third party involvement in the death. However, with this death it was apparent that something untoward had occurred.

63. When CCTV footage was viewed, it showed several prisoners entering the man's cell together at the point in time that the wing officers attended to the

[1] A defibrillator checks for presence of electrical activity in the heart and emits audible instruction about management of the patient.

prisoner who had collapsed on the lower landing. Prison staff identified for the police the prisoners apparently involved. The police interviewed those prisoners as well as others who it was believed might be witnesses.

64. Peterborough's then Director gave a briefing to staff that night. Two members of the Samaritans were called into the prison the following day in order to provide support to prisoners and staff. The Samaritans were briefed on their arrival in the prison about the suspicious nature of the man's death.

65. Because of the apparently suspicious circumstances surrounding the death, the prison agreed that police officers should break the news to the man's family. A prison family liaison officer was appointed and he subsequently met the man's wife, his nominated next of kin. The prison held a memorial service which his wife attended. Peterborough contributed to the funeral expenses.

66. The police investigation team took statements from various members of staff. Most of those who expressed comments about the man described him as polite and compliant with the prison regime and most seemed unaware of any feelings of resentment towards him from other prisoners. However one member of staff, a principal officer, wrote in his statement that the man was "a bully … into the drug culture on the wing … a staff manipulator who tried to get to no-go areas with staff on the wing." Due to this staff member's long term absence from work through ill health, my investigator was not able to interview him.

67. My investigator spoke with Peterborough's Head of Male Residence at the time the man was in the prison. My investigator asked about the use of SIRs in managing prisoner behaviour. She said that any information highlighting a prisoner as a potential bully would be discussed at the monthly safer custody and violence reduction meeting. She said that a member of the security team would also be a member of the violence reduction committee and that there is regular liaison between the safer custody senior officer and security and a monthly report is completed. That information is discussed at the violence reduction meeting. If a pattern of inappropriate behaviour was highlighted a decision would be made about how to deal with that. She said that If there is corroborated evidence or continued evidence that some form of bullying is taking place, the prisoner will be placed on "stage 2" of the anti-bullying procedure. That could mean reducing the prisoner's IEP level to "basic" for a period of time, and the next stage would be a move the separation and care (segregation) unit.

68. However, she could not recall the man being discussed at the safer custody and violence reduction meetings and could not recall anything emerging to suggest that he was involved either in bullying or being targeted by others.

69. My investigator spoke with a Principal Officer (PO) about the response by officers to the apparent medical emergency that occurred on the lower landing on X2 wing on the evening of 11 September which left the upper landing unsupervised. My investigator asked whether one of the officers should have continued to supervise the wings leaving the other two officers to

deal with the emergency. The PO said that prisoners will use distraction tactics to draw staff attention while other prisoners exchange forbidden items, such as notes and drugs. However, staff are trained to respond to medical emergencies and in the case of a person having a fit, the person can often be violent during the fit and in danger of harming themselves as well as others. He said that if an insufficient number of staff responded to such an incident, Peterborough could be open to criticism.

The man's cause of death

70. A Home Office consultant forensic pathologist was instructed to carry out a post mortem examination on the man. He conducted preliminary and final post mortem examinations and he wrote reports following each. He also wrote two supplementary reports. His findings from his final post mortem examination included that:

> "There is evidence of significant natural disease in the heart with severely stenotic coronary atherosclerosis in the left … coronary artery (narrowing of the artery through a fatty build up). This would have made the deceased potentially vulnerable to the development of sudden cardiac dysrhythmia (abnormal electrical activity in the heart), particularly in circumstances of stress …
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> "The findings in relation to the facial area and head are in keeping with multiple blunt force impacts. There is also evidence of blunt force impacts and/or gripping on the upper and the lower limbs as well as on the trunk. These findings overall are consistent with multiple blunt impacts such as from fists or mild to moderate force kicking. There is however no evidence of any severe force kicking or other severe force blunt impact …
>
> "On the basis of a lack of any fracturing or intracranial haemorrhage it appears that the nature and extent of head and facial impacts falls short of that normally associated directly with fatality. In my opinion the most likely scenario is that the stress of an assault has precipitated a fatal cardiac dysrhythmia in the face of significant underlying ischaemic heart disease ..."

71. The pathologist gave the cause of death as:

> "1a Blunt force injury to head and face in association with underlying ischaemic heart disease."

72. In his first supplementary report, the pathologist wrote:

> "There is a history of heavy smoking which would be a significant risk factor for the development of coronary artery disease. In the [community general practice] notes there is an entry [from 2003] when left sided chest pain was complained of. In the prison records there is an entry dated 19 June 2008 … when chest pains were complained of. On neither occasion was it suggested that these symptoms might have been related to ischaemic heart disease and it does not appear that any further

investigations were instigated. In retrospect it may be that the symptoms complained of on either or both occasions were attributable to ischaemic heart disease. However this would be to some extent speculative.

"Importantly, there is no evidence that the deceased was complaining of any symptoms which in retrospect might be attributable to ischaemic heart disease in the days leading up to his death … "

73. The pathologist produced a second supplementary report when asked to consider the man's chances of survival in the case that he had received immediate medical attention. His opinion was that even in that situation, the prognosis for him would still have been very poor with his chances of survival probably being less than ten per cent.

74. Based upon all of the information before it the Crown Prosecution Service decided that the prisoners apparently involved in the assault should be prosecuted for manslaughter. One prisoner pleaded guilty and five others were put on trial. Of these five, two were convicted of manslaughter and the remaining three were acquitted.

ISSUES

75. The prisoners directly involved in the attack upon the man that resulted in his death were prosecuted, convicted of manslaughter and duly sentenced. This report focuses on any potential areas of learning for Peterborough.

Security and other reports about the man's behaviour

76. The man's records indicate two distinct sides to his personality. In terms of his interaction with staff, it seems that he was generally polite and compliant with the prison rules and regime. It is also clear that he was a hard worker. His final job was principal servery worker on X2 wing and several positive entries were made in his records about his performance in this role. Other entries in his records however refer to him sometimes interacting inappropriately with staff. This, it seems, related to him being over familiar in the sense of behaving towards staff more as would a peer, rather than as should a prisoner.

77. With regard to his relationships with other prisoners, his records contain a number of entries indicating that some prisoners considered him a bully or an intimidating presence. On one documented occasion on Z2 wing he exchanged blows with another prisoner. The two prisoners each blamed the other for the incident so neither prisoner was deemed the guilty party. Even so, the man was moved to X2 wing and for a seven day period and was subject to anti-bullying monitoring. Immediately before his transfer two prisoners reported to an officer that there was "bad feeling" towards him so that it would not be wise for him to remain on the wing. This would seem to be the only incident of potential bullying on the man' part that was properly investigated.

78. During the man's time on X2 wing two separate reports were made about him issuing threats to other prisoners about unpaid debts. One of these reports led to him being monitored for three days. These were not the only reports submitted about him. Another was about him giving out short servings on the servery and stealing the surplus. One more was made by the prisoner with whom he had had an altercation on Z2 wing. This prisoner complained that he was continuing to send threats to him even though they were living on different wings.

79. Prison Service Order (PSO) 2750 provides prisons with guidance and instruction on the issue of violence reduction. PSO 2750 points out that staff need to be aware that prisoners who are at risk of being victimised might be tempted to use violence to defend their interests. PSO 2750 goes on to say that prisoners involved in unacceptable behaviour must be challenged through:

    - staff intervention to resolve conflict in its early stages will reduce likelihood of escalation to physical violence and need not always necessitate disciplinary action.

- constructive sanctions and incentives such as [the Incentives and Earned Privileges scheme (IEP)] are appropriate for some prisoners, but must be part of a package of measures which address the causes and contributory factors.

80. PSO 2750 also instructs that any incidence or pattern of unacceptable behaviour must be clearly recorded on the prisoner's history sheet. Further advice about managing unacceptable prisoner behaviour is contained throughout the PSO.

81. The man's history sheet was not used in the way required by PSO 2750. There are sporadic entries about some of the incidents that occurred between him and other prisoners, but an insufficient number are included to suggest any pattern. The staff with whom my investigator spoke were essentially unaware of any history of inappropriate behaviour on his part and unaware of any feelings of resentment from other prisoners towards him.

82. Nothing is recorded to show whether thought was being given at any stage to discussing with the man any pattern in his behaviour. Nor is anything recorded about whether thought was ever given to reducing his IEP level.

83. In addition, the man was able to secure for himself the position of principal servery worker. I understand this to be a coveted job and as such, I would expect the person appointed to be among the more trusted and well behaved of prisoners. I would question the process through which the man came to be appointed to this position given his wing history.

I recommend that the Director remind staff about the guidance and instruction in PSO 2750 in dealing with inappropriate behaviour and violence reduction.

I recommend that the Director consider, and revise if necessary, procedures for adequate copying into prisoner history sheets of relevant security information.

I recommend that the Director consider, and revise if necessary, procedures for proper use of security information when allocating jobs.

Possible motivation for the assault on the man

84. Despite the incidents that led to adverse reports being written about the man, the precise motivation for the assault on him remains unclear. None of the prisoners involved were among the number who had been threatened by him or involved in any recorded altercation with him. Moreover, according to his friend neither he nor the man suspected that an attack was being planned. Indeed, a viewing of the CCTV recording for the evening of 11 September shows the man walking about the wing in what appears a comfortable and confident manner. His friend said that as the other prisoners came into the cell they accused the man of being an informer. However, I have seen no evidence to support such an accusation.

85. Press reports of evidence that emerged at the trial of the three prisoners later convicted of manslaughter referred to resentment of him due to a "reputation for dealing in drugs and tobacco". An SIR report in January 2008 detailed an incident where he and another prisoner appeared to have exchanged an item that each of them appeared to have taken pains to conceal. The implication was that the item, if there was one, was a prohibited item, for instance drugs. However, neither prisoner was searched it would seem so nothing was proven. Five months later, the man failed a mandatory drug test. These two incidents apart, there is no other evidence that he might have been involved in the buying and selling of drugs.

86. There is some evidence that the man was involved in buying and selling goods on the wing. This would probably have been the buying and selling of prison canteen items such as cigarettes and foodstuffs. Two of the security information reports about him allege that he was sending threats to other prisoners about unpaid debts. These might have been debts about the failure to pay for canteen items supplied by him, but this is speculation. The CCTV recording from the night of the man's death shows prisoners involved in the assault walking out of his cell afterwards carrying items which presumably belonged to him. These might have been items that he was planning on selling on, but this again is speculation.

87. I accept that the buying and selling of goods probably goes on in all prisons and is a difficult practice to control. Nevertheless, the practice is forbidden within Peterborough's wing rules, as it is in all prisons.

I recommend that the Director remind staff to be vigilant in identifying prisoners involved in the buying and selling of goods.

Cell bell alarm system

88. All prison cells are fitted with cell alarms to allow prisoners to call for assistance at times when they are locked in their cells. Prisoners are instructed that cell alarms should only be used in the case of an emergency. Consistently, however, most cell alarm use in most prisons are for reasons other than an emergency. In Peterborough, the cell alarm system is supported by the use of in-cell intercoms. When the prisoner activates the cell alarm, the call goes to a central control point on the wing. An officer there will speak to the prisoner via the intercom to find out the reason for the call. The central control point will usually be staffed, but there will be times when the staff might be elsewhere dealing with other matters. In that case, cell alarms will be diverted to the main communications room if they remain unanswered after 60 seconds. The main communications room is never left unstaffed.

89. Cell alarm use by cell is recorded on an electronic system. The records show that the man's cell alarm was activated three times in quick succession on the evening of 11 September, although the times recorded are around 20 minutes earlier than the time of the assault. The recording sheet contains a column

where the reason for the alarm call should be entered. For all three calls "none" has been entered as the reason for the call. All calls were disconnected in less than a second.

90. My investigator spoke to the prisoner who was in the man's cell when the other prisoners entered and carried out the assault. The prisoner said that he had been chatting with the man, who was unaware that other prisoners were planning to assault him. When the other prisoners came into the cell, one of them accused him of being a "grass", which he denied. The prisoner began punching the man, who pressed the cell alarm button twice. The friend also pressed the alarm button. None of the calls were answered. The friend said that the assault was not very severe. After the others left the cell the friend asked the man if he should call an officer or a nurse. The man replied that he was fine and that he did not want anyone to be informed. The friend left the cell to smoke a cigarette. Afterwards, he briefly returned to the cell and the man still seemed fine. The friend left once more and did not see the man again.

91. My investigator spoke to a number of other prisoners to ask about their experiences of staff response when pressing cell bell buttons. Responses were mixed. A minority of prisoners reported never having a problem in obtaining a prompt response. The majority, however, reported problems from time to time. This included instances when their calls appeared to be immediately disconnected without anyone asking the nature of the problem.

I recommend that the Director should commission or conduct an audit of the cell alarm system and to assure himself of its integrity.

Provision of radios

92. My investigator asked the Head of Male Residence about the number of radios allocated to staff. In particular about the fact that one of the three officers on duty on X2 wing on the evening of 11 September was not carrying a radio. She said that the reason Peterborough restricted the number of radios was to control the amount of radio traffic and to thereby lessen the possibility of important calls being blocked.

93. At the point that one of the prisoners collapsed on the lower landing, the first PCO was in the wing office dealing with paperwork. Another prisoner alerted her to the fact that a prisoner had collapsed to the floor. She checked the prisoner and decided that he should be examined by a nurse. However, she had no radio. The reason for this was because only two radios were shared between the three officers on duty. The other PCOs were patrolling the wing so they each had a radio. As she was dealing with paperwork she was not considered to have the same level of need for a radio so one was not allocated to her.

94. I understand that radios are now carried by all officers on duty on a wing and so I make no recommendation.

Deployment of staff to stop assaults

95. The CCTV recording for the evening of 11 September would appear to suggest that the timing of the assault on the man had been pre-planned. At around 7.50pm a prisoner collapsed to the floor on the ground landing. All three officers on the landing went to the aid of the prisoner and at that point other prisoners entered the cell where they assaulted the man. My investigator explored with senior staff at Peterborough the response by officers to the apparent medical emergency when a prisoner collapsed to the floor on the lower landing. All three officer on the wing responded to the incident and this left the upper landing unsupervised. I accept the point made by the PO about the need for a sufficient number of staff to be present in the case of a possible medical emergency. In addition, in the case of a fight between two prisoners, even three staff might prove insufficient to deal with the situation. The inevitable consequence is that it is not possible for all prisoners to be supervised at all times.

96. In a thematic review into "out of cell" activity, Her Majesty's Chief Inspector of Prisons commented that the amount of time that prisoners are able to spend out of their cells is a key determinant in the overall health of a prison, is a crucial part of rehabilitation, and critical to the mental health and wellbeing of prisoners. Out of cell activity includes the amount of time that prisoners are able to engage in purposeful activity, such as education, work and offending behaviour programme, but also includes time spent in exercise, in association with other prisoners, and in basic tasks such as showering and using the telephone. The Chief Inspector goes on to say that these activities are part of the "dynamic security" of a prison, which depends as much on activities and relationships as it does on physical security.

97. I concur entirely with the Chief Inspector's views on the benefits of out of cell activity; however one effect is that during association periods a large number of prisoners are moving freely around the prison wing while being supervised by a small number of staff. The CCTV footage of the evening of 11 September shows that immediately before the attack on the man, the three officers on duty had positioned themselves in a way that meant both landings were well supervised. The officers then responded to the apparent medical emergency and could not have been expected to anticipate that an attack on another prisoner was about to be launched. I would not criticise the officers for their actions, even so the Director might wish to remind staff about the need for constant vigilance.

CONCLUSION

98. The death of one prisoner at the hands of another is a rare event. The courts have found that the prisoners who carried out the assault on the man had not intended to bring about his death. Unfortunately he had an undiagnosed heart condition and the stress of the assault resulted in him suffering a cardiac arrest. The precise reason for the assault remains unclear. There are several possibilities, such as his apparent involvement in the buying and selling of goods and a suggestion that he might have been dealing in drugs. What appears clear, however, is that he seemed unaware that he might be at risk from other prisoners. Although it is clear that several prisoners had alleged wrongdoing on his part, I do not believe that the assault could have been predicted or prevented.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Prison Service's response to the recommendations appears in italics below each recommendation:

1. I recommend that the Director remind staff about the guidance and instruction in PSO 2750 in dealing with inappropriate behaviour and violence reduction.

   Prison Service response: Recommendation accepted. A review of inappropriate behaviour and safety is underway to give strategic direction to the Safer Prison agenda. A Notice to Staff highlighting the importance of dealing with inappropriate behaviour will be issued. Target date for completion is the end of June 2011

2. I recommend that the Director consider, and revise if necessary, procedures for adequate copying into prisoner history sheets of relevant security. information

   Prison Service response: Recommendation accepted. This will be discussed on the monthly bi-lat with the Head of Security. Once completed instructions will be given to all staff as to how this work will be managed while maintaining the integrity of intelligence information. Target date for completion is the end of May 2011

3. I recommend that the Director consider, and revise if necessary, procedures for proper use of security information when allocating jobs.

   Prison Service response: Recommendation accepted and implemented. Security information is considered when allocating all workplaces, and a full allocation board is held weekly.

4. I recommend that the Director remind staff to be vigilant in identifying prisoners involved in the buying and selling of goods.

   Prison Service response: Recommendation accepted. To be discussed with the Head of Male Services and the Stores/Shop Manager to introduce methods to identify those prisoners suspected of dealing in goods. This will then be brought to the attention of staff through the daily briefings. Target date for completion is the end of May 2011

5. I recommend that the Director should commission or conduct an audit of the cell alarm system and to assure himself of its integrity.

   Prison Service response: Recommendation accepted. The IT department through the Facilities Manager will conduct an audit of the cell alarm system and report findings to the Director. Target date for completion is the end of May 2011