A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in January 2013, while a prisoner at HMP Hewell

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death on 31 January 2013 of a prisoner at HMP Hewell. The man had been the victim of a serious assault at the prison on 28 January and died in hospital as a result of the injuries sustained. He was 22 years old. I offer my condolences to the man's family and friends.

The investigation was suspended pending a criminal investigation and court proceedings. I regret the consequent delay in issuing this report. HMP Hewell cooperated fully with the investigation.

The man had been at Hewell since October 2012, awaiting trial on charges of burglary and other offences. On the morning of 28 January, some property went missing the cell shared by the first and second prisoner. It was later returned by the man's cellmate who said he had obtained it from another prisoner. The cellmate was moved to the segregation unit that morning as there was also some information that he had concealed some weapons on the wing. After lunch that day, the man was found severely injured in the first and second prisoners' cell. He died in hospital three days later. Three prisoners stood trial for the man's murder. Two were acquitted, but the first prisoner was found guilty. This investigation has examined if there was anything the prison could reasonably have done to protect the man.

The man had been assaulted at the prison five days before he was fatally injured. Although there is little to connect the two incidents, more could have been done to investigate the circumstances and safeguard the man after that assault. It appears that the subsequent fatal assault was a result of reprisals against the man, either because of his association with his cellmate or because his assailants suspected him of being involved in the cell thefts. I am concerned that there appears to have been a general problem of cell thefts in the prison at the time about which little appears to have been done. While I do not consider that the prison could have anticipated such an extreme violent reaction against the man, there appeared to have been little consideration that the events that morning might have made him vulnerable to attack. One officer said he raised this concern with his managers, but they deny this. Whether or not this was the case, the man's potential vulnerability and the possibility of reprisals against him should have been considered.

It took too long to notify the police of this serious assault, during which time important evidence could have been lost. I am also concerned that, in the aftermath of such a violent and tragic death, the man's family did not believe that they were treated appropriately by the prison. It is important that prison managers deal with bereaved families in such circumstances with sensitivity and respect.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2014**

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SUMMARY

1. The man was remanded to HMP Hewell in October 2012 charged with offences of burglary, aggravated vehicle taking and possession of cannabis. He had been released on licence from a prison sentence in June 2012 and his licence was later revoked.

2. On the morning of 28 January, the first prisoner, whose cell was opposite the man's, found his cell in disarray and some of his possessions missing. An officer locked the first prisoner into his cell and told him that he would find out what had happened. As the officer was going from cell to cell, the man's cellmate told him that he had the missing items which he had obtained from another prisoner and which he said he would return. Although missing items were returned, the first prisoner believed that some items were still missing and was very angry.

3. Around an hour later, another prisoner reported to officers that the man's cellmate had a number of improvised weapons and was intending to assault the second prisoner (the first prisoner's cellmate).

4. The second prisoner returned to the wing from work at midday. He found that some of his possessions had also been taken and other prisoners heard him make serious threats against whoever was responsible.

5. At about this time, prisoners began to collect lunch and went back to their cells to be locked up over lunch time. At the same time, officers moved the man and his cellmate from their cell (A309). The man was moved to a different cell on the landing and his cellmate was taken to the segregation unit. Officers wanted to check cell A309 for any other items of property belonging to the first and second prisoners and also to search for any weapons.

6. Cells were unlocked again after lunch at about 1.30pm. About 15 minutes later prisoners called out to officers that they were needed urgently. They found the man lying in a pool of blood on the floor of the first and second prisoners' cell. The man was taken to hospital where he remained in intensive care for three days. He died in hospital on 31 January 2013. The prison did not notify the police of the assault until two and a half hours later.

7. Three prisoners were subsequently charged with the man's murder. At trial, two of the defendants were acquitted but the first prisoner was found guilty.

8. This investigation has found that staff should have been aware of the potential risk to the man and more should have been done to protect him. We make six recommendations.

THE INVESTIGATION PROCESS

9. The investigator made a preliminary visit to Hewell on 12 February 2013 and met the Governor and other prison staff. He went to the wing and cell where the assault on the man took place. The investigator also met the senior investigator from West Mercia Constabulary to discuss the evidence they had collected.

10. In accordance with the Ombudsman's terms of reference and agreement with the police, the investigation was suspended while West Mercia Police conducted a criminal investigation into the circumstances of the man's death and during the subsequent criminal proceedings.

11. Three prisoners were tried for murder: one was found guilty and the other two were acquitted. After the criminal proceedings concluded, the investigator interviewed nine members of prison staff at HMP Hewell.

12. The investigator wrote to the Coroner to inform him of the Ombudsman's investigation and a copy of this report has been sent to him.

13. One of the Ombudsman's family liaison officers contacted the man's family to inform them of the investigation and to ask them to identify relevant issues that they wished the investigation to consider. The family liaison officer spoke by telephone to one of the man's brothers who said his family had a number of questions and concerns:

    - The man was possibly assaulted by his cellmate a few days before the fatal assault. Why did they continue to share after this?
    - The man had written to his family around 23 January saying that he was concerned for his safety. What had the prison done about this?
    - The man had put in a number of transfer requests because of bullying. What had been done about this?
    - It was several hours after the fatal assault before his family were informed that he had gone to hospital and his family were concerned that the man could have died in the meantime.
    - Prison officers remained in the man's hospital room until his family asked them to leave.
    - After the man's death, his family received a condolence letter in February 2013 sent by second class post, which they believed was backdated to 31 January 2013.
    - His family attended a pre-arranged visit to the prison after the man's death, but the Governor was not present.

14. The man's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP HEWELL

15. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as a category D open prison and the Blakenhurst site is a category B local prison. The man was at the Blakenhurst site which comprises six houseblocks. Houseblocks one to three are for mainstream convicted prisoners. Houseblock six is for remand prisoners and prisoners on induction. The remaining two houseblocks are for vulnerable prisoners and those receiving treatment for substance misuse.

Her Majesty's Inspectorate of Prisons

16. The last inspection of Hewell was in November 2012. The Chief Inspector's comments included:

    "Work on some security issues had improved but significant weaknesses remained. The use of intelligence was improving as was the number of security information reports received; however, the way in which other relevant security data was collected was not always effective and the analysis of information was often poor. Some dynamic security elements were weak. The security committee was reasonably well structured but attendance at meetings, particularly from managers in some important areas, was inconsistent. Formal links with key areas such as safer custody … were underdeveloped ….

    "There was a comprehensive safer custody policy, but this had not been based on a needs analysis. The safer custody team met monthly but attendance had declined and key stakeholders, including … security staff, did not always attend. Monitoring data was not being used effectively enough to inform the local strategy.

    "… There had been 94 reported prisoner-on-prisoner assaults … in the six months prior to the inspection, which was significantly higher than at other similar prisons ... but under-reporting was apparent … There were gaps in the log which meant data about unexplained injuries was unreliable and of those identified, 20 had not been investigated.

    "Staff did not adhere to the antisocial behaviour procedures outlined in the local policy … In addition, levels of staff supervision of prisoners were not always sufficient … The approach adopted did not reassure us that problematic behaviour was being dealt with robustly …"

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In its annual report for the period to 30 November 2012, the IMB noted that the prison had faced many challenges during the year, but believed that a new Governor had brought focus and a

clear sense of direction. The IMB noted that, while safer custody meetings were thorough with effective follow through, some managers did not attend consistently.

Previous deaths at HMP Hewell

18. There have been 15 deaths of prisoners at HMP Blakenhurst/HMP Hewell since the Ombudsman was given responsibility for the investigation of deaths in custody in April 2004. The man's death was the only murder.

KEY EVENTS

19. The man was born in June 1990. He was arrested on 25 October 2012 and charged with offences of burglary, aggravated vehicle taking and possession of cannabis. He spent the night in police custody and was remanded to HMP Hewell the next day.

20. At a routine healthcare reception screen, the man was assessed as fit and well with no health concerns. He was placed on A spur of houseblock six (the induction wing). The man had been released from prison on 20 June 2012 on conditional licence and on 26 October his licence was revoked.

21. On 29 October, the man was one of four prisoners named in a violence reduction report after an officer noticed a disturbance on the wing. Explanations from prisoners differed, but it appears that the man had an altercation with a prisoner who had links with a notorious street gang from Coventry and two other prisoners intervened on the man's behalf. The man told an officer that he was concerned about repercussions if he were to remain on A spur and so he was moved to B spur. His records contain an undated, unaddressed letter about this issue indicating that a prison manager had told him that he was on a waiting list for a transfer to HMP Birmingham.

22. On 14 November, the man was put on basic regime (the lowest level of prison regime) for refusing to move to houseblock one. He did not give any justification for refusing and was told he would remain on the basic regime until he moved.

23. On the evening of 4 December, officers noticed a group of around 12 prisoners on houseblock six moving from cell to cell during the association period. Two officer's intervened and the prisoners told them that they were trying to find out about a number property thefts from cells in the previous few days. The officers told the group to stop what they were doing as it was the prison's responsibility to deal with complaints about property theft. While the officers were speaking to the main group, they noticed that three prisoners from the group, including the man, had broken away and gone to an unoccupied cell to search for missing property. The officers ordered the three prisoners to come out of the cell. At that point the prisoner whose cell it was arrived and had to be placated.

24. The next day, the prisoners who had formed the group the previous evening were dispersed to different locations around the prison. The man was moved to houseblock two.

25. Several entries in the man's prison records from 5 to 20 January 2013 referred to him being reluctant to leave the wing for work as he said he was under threat from other prisoners, but he refused to name them. One entry noted that while the man was reluctant to attend work, he continued to go to the gym and to take part in other activities. One officer speculated that the man was claiming to be under threat in order to avoid work.

26. In the early afternoon of 23 January, the man told an officer that he had been assaulted. The officer noted that:

> "… [the man] … reported to me that he had been assaulted on the lower walkway … during movement to labour … [by] three people … He doesn't know who they were … [the man] refuses to [move to the vulnerable prisoners' unit] and is happy to remain on [this wing]. He has been removed from [his work placement] as we can't guarantee his safety off the residence unit."

27. A nurse examined the man and recorded that he had:

> "… swelling and small laceration to face … no blurred vision nausea or vomiting … pupils equal and reacting … no treatment required."

28. Two hours later, the man told an officer that the people who had assaulted him were the same ones he had had problems with when he was on houseblock six.

29. The man wrote a letter of complaint the next day to the Head of Reducing Re-Offending at the prison, in which he explained:

> "… Basically, I was supposed to have been [transferred] to Birmingham due to conflict [at] Hewell. I have told officers several times that my life is in danger [here] due to me having trouble with Coventry prisoners that are all over this jail but nothing seems to be getting done. I was assaulted yesterday [and] suffered a broken nose, broken cheek bone. I have told staff … because next time it could be … fatal."

30. The man put the letter in an envelope addressed to the head of Reducing Re-Offending and posted it in the wing complaints box. The letter remained unopened for several days as the head of Reducing Re-Offending was not on duty and was not due back in the prison until 30 January.

31. The man asked for his injuries to be re-checked on 24 January as he thought that his facial swelling had increased overnight. He also thought that his vision was blurred and his nose did not "feel right". A nurse noted increased swelling to the man's nose and under his eye but also noted that his pupils appeared normal and were reactive to light. She prescribed medication for the swelling and pain and planned to review him four days later.

32. On the same morning, a senior officer (SO) started an investigation into the assault. He spoke to the man, who repeated what he had previously told the officer. The SO asked the man if he wanted the assault to be reported to the police and he said that he did not. Shortly after this, another prisoner reported to the SO that he understood that it was the man's cellmate who had assaulted him. The SO passed the information to the safer custody team.

33. Two officers from the safer custody team asked the man whether his cellmate was responsible for assaulting him. The man denied this and said that he

was “happy to share the cell and that he [got] on really well with [his cellmate]”. The officer wrote in a violence reduction report that while officers suspected that the man’s cellmate might have been responsible, there was no significant evidence to support this and the man had denied it. No one spoke to the cellmate about the allegation. The officer noted:

> “… The man is clearly worried about his safety and would like to move to another prison. He says that at this time he feels safe … on [houseblock two] but is very reluctant to leave the houseblock at all.”

34. The officer recommended trying to facilitate the man’s transfer to another prison and opening a ‘tackling antisocial behaviour’ (TAB) document which are used to help manage victims or perpetrators of potential antisocial behaviour and bullying. A TAB document was opened that morning.

35. The TAB procedures include an observation plan. The man’s plan was for three observations a day to ensure he was collecting meals and mixing with other prisoners. Officers recorded only two observations each day, but these indicated that he spent a lot of time out of his cell associating with other prisoners without giving any cause for concern. None of the entries suggested there was any evidence that that the man was being bullied by his cellmate.

28 January 2013

36. The first and second prisoners shared cell A304 and the man and his cellmate shared cell A309 on houseblock two. At about 8.20am on 28 January, the first and second prisoners went to their prison jobs. The first prisoner asked an officer (the first officer) to lock the cell and the first officer said he would do so once movement to labour had been completed. (Cells at Hewell have privacy locks which are designed to allow prisoners to close their doors securely when they leave their cells. However keys often go missing and it appears that this was the case at the time at Hewell. In these circumstances the doors can only be locked by an officer.) We do not know how long the door was left open before the officer was able to lock it.

37. When the first prisoner got to his allocated workshop, the workshop was full so he went back to his houseblock. The first officer took the first prisoner to his cell and unlocked the door. The cell was in an untidy state and the first prisoner noticed that some personal possessions were missing. He was extremely angry but the first officer told him that he would deal with the problem and locked the first prisoner into the cell.

38. As the first officer began to check the other cells on the landing, the man’s cellmate told him that he had the possessions and that he knew who had taken them. The man’s cellmate took four bags of belongings back to the first prisoner. The first officer then locked the man’s cellmate back in his cell and went to speak to the first prisoner. He was not sure whether all of his property had been returned so the first officer told him to check and let him know if there were any missing items. He then locked the cell.

39. The first officer said that after a while the first prisoner pressed his cell call button to say that some of his property was still missing and he was unsure about the second prisoner's belongings. The first prisoner was still angry and he shouted across to the landing asking the man's cellmate to explain why he had had his property.

40. The first prisoner told the investigator that he had shared a cell with the second prisoner for around two weeks. He was concerned that the privacy lock on his cell door did not work and when he complained officers told him that the keys were missing. He asked officers each morning to lock his cell when he went to work and did so again on the morning of 28 January. The first officer told him that he would lock the door once he had ticked off the names of all the prisoners on their way to activities. The first prisoner said that he returned to his cell around 20 minutes later and found that a lot of property was missing, especially the second prisoner's property. When the man's cellmate brought several bags of property back to the cell he found that most of his property had been returned but a lot of the second prisoner's property was still missing and milk had been spilled on some of the second prisoner's letters. The first prisoner said that he rang his cell bell and told the first officer. He also asked the first officer if he could be moved to a cell with a working privacy lock. The first prisoner said that he later learned that the second prisoner and the man's cellmate had once shared a cell but they had fallen out and that the man's cellmate had intended to take the second prisoner property.

41. Shortly afterwards, another prisoner told the first officer and the wing SO that the man's cellmate had concealed weapons around the wing and was intending to attack the second prisoner. The wing SO told the investigator that it was during this conversation that he learnt that the man might have been bullied by his cellmate. The wing SO decided that the cellmate should be moved to the segregation unit pending investigations into the allegations.

42. The second prisoner returned from work at around 11.30am and discovered that belongings had been taken from his cell. Another prisoner said he heard the second prisoner say: "I'm not interested in parole, I'm gonna kill someone over this". The first prisoner said that he had also heard the second prisoner say this.

43. The investigator asked the first officer at interview why the man had been left on the wing on 28 January with no thought apparently given to the possibility that he might be vulnerable to an assault by either the first or second prisoner. The first officer said that he had been concerned about this and had reported his concerns to the wing SO and the Orderly Officer (the senior officer responsible for the day to day running of the prison). Both of those officers denied at interview that the first officer had reported any such concerns to them.

44. Prisoners collected their meals between 11.45am and 12.15pm and all prisoners were locked into their cells by 12.30pm. The Orderly Officer went to

houseblock two to authorise the cellmate's segregation and to assist officers in moving him. The man was moved to cell A312, a cell three away from his previous cell and still on the same landing. This left cell A309 vacant and ready to be searched for weapons and any remaining property belonging to the first and second prisoner or other prisoners.

45. At 1.30pm, an officer unlocked the cells on the A3 landing and then went down to the A1 landing. About 15 minutes later he heard a voice from the A3 landing calling for assistance. He responded and found the man semi-conscious lying on his back on the floor of cell A304, the cell shared by the first and second prisoners. He had facial injuries and was bleeding heavily. The officer radioed a code red emergency and asked for an emergency ambulance. The ambulance was called at 1.50pm.

46. The wing SO arrived and he and the officer placed the man on his side so he could breathe more easily. Two nurses and then a doctor attended and remained with the man until paramedics arrived. They treated the man and then took him to the nearby Alexandra Hospital in Redditch, where he arrived at about 3.00pm.

47. Hewell's management team were at a strategic planning meeting away from the prison that day and a senior member of staff from a nearby prison was acting as the interim duty governor. One of Hewell's family liaison officers, was told at about 4.00pm that the man had been seriously assaulted that afternoon, that his injuries were life-threatening and that he was being treated at the Alexandra Hospital.

48. The family liaison officer maintained a detailed log of events. She noted that at 4.15pm she had asked a governor if she should contact the man's family and was advised to wait an hour for more "up to date information" on the man's condition and also because the man was due to be transferred to a different hospital. The family liaison officer asked several more times for permission to contact the man's family and was eventually told that she could to do so at 5.25pm. She then telephoned his family home and told one of the man's brothers that the man was in hospital with a serious head injury and that he was due to be transferred to Walsgrave Hospital, Coventry, later that day. The man arrived at Walsgrave Hospital at around 7.30pm where his family were waiting for him.

49. The man remained in intensive care for three days, but died on the evening of 31 January. A post-mortem examination gave his cause of death as raised intracranial pressure secondary to head injury.

50. The prison did not inform the police of the assault until 4.14pm that day – two and a half hours after the staff became aware of the assault. Police then attended the prison and interviewed prisoners and staff. The evidence they collected suggested that four prisoners were possibly involved in the assault and all four were arrested and charged. Subsequently, the first and second prisoners and one other prisoner were tried for the man's murder in November 2013. The fourth prisoner was found unfit to stand trial due to the state of his

mental health. The first prisoner was found guilty and sentenced to life imprisonment. The two other defendants were acquitted.

51. The first prisoner told the investigator that it was not him who had attacked the man. He said that he had got most of his property back so he had no reason to attack anyone. He said that after the incident the second prisoner had left the cell and changed his clothes and footwear.

ISSUES

Response to the assault on the man on 23 January

52. On 23 January, the man told the officer that three prisoners, whom he did not know, had assaulted him while he was on his way to work. He was offered the option of moving to the vulnerable prisoners' unit but he said he wanted to remain on houseblock two.

53. Another prisoner told staff that he believed that the man's cellmate was responsible for the assault. An officer from Hewell's safer custody team was unable to find any evidence of this and the man denied this, but no one put the allegation to the man's cellmate. The officer advised that efforts should be made to see if the man could be transferred to a different prison, which he wanted, and that a TAB plan should be opened. Checks made on the man during the next few days showed that he was mixing well with other prisoners on the houseblock and gave no cause for concern. Other than the evidence from one prisoner there was no other intelligence to suggest that the man was at risk from his cellmate. Nor was there any evidence that the man was at risk from the first and second prisoners.

54. The man either would not, or could not, name the person or persons who had assaulted him. Apart from the actions that were taken, the only other practical step that could have been taken at that time would have been to separate the man from his cellmate if there was any possibility that he was being bullied by him. When officers asked the man about this on 24 January, he denied that the his cellmate was responsible and he said he was "happy" to continue sharing with him. No one spoke to the cellmate about this to gauge his reaction to the allegation. On 28 January, the wing SO learnt about the allegations that the cellmate had concealed weapons and had assaulted the man. He segregated the cellmate until the allegations could be investigated. Despite the man's assurances that his cellmate had not assaulted him, we consider it would have been prudent to separate the two at an earlier stage. When a prisoner is being intimidated by a cellmate they will often be unwilling to report this for fear of being labelled a 'grass'. We make the following recommendation:

    The Governor should ensure that prisoners are separated when there is information to suggest that a prisoner might be at risk of harm from his cellmate.

The man's complaint and transfer request

55. On a complaint form dated 23 January, the man complained about the lack of response to his request for a transfer to another prison. He referred to having problems with prisoners from Coventry and that he had been assaulted and injured the day before (the reference to the assault having occurred the day before suggests that the complaint was misdated and was actually written on 24 January).

56. The man used the ‘confidential access complaints’ process to send his complaint in a sealed envelope to Hewell’s then Head of Reducing Re-Offending. The head of Reducing Re-Offending was not on duty for several days and due to the confidential access marking on the envelope, it remained unopened.

57. The confidential access complaints process allows prisoners to complain confidentially and directly to the governor in charge of a prison, the chair of the local Independent Monitoring Board or the regional deputy director of custody. The rationale for this process is to allow prisoners to complain directly at a senior level about particularly serious or sensitive matters which they might be reluctant to discuss directly with officers. It is for the recipient to decide how the complaint should be handled once it reaches them. If confidential access is inappropriate then the recipient can answer if the matter can be dealt with easily of quickly, they can refer it to another manager or they can return it to the prisoner explaining how to pursue the matter through the normal channels.

58. As the head of Reducing Re-Offending was not among the very limited group to whom a confidential access complaint can be sent, the man’s complaint should have been directed elsewhere or returned to the man. Hewell reviewed its complaints system after the man’s death. Misdirected confidential complaints such as his are now returned unopened to the sender with a note explaining the correct process.

59. An officer from the safer custody had suggested that the man’s transfer request should be looked into – as well as recommending an anti-bullying action plan. Her plan appears to have been a reasonable one and she spoke to the man who told her that he felt safe on the houseblock, so there appeared to be no urgent need for a move. Even if the man’s transfer request had been approved it is unlikely that it would have happened immediately or before the events of 28 January. There is nothing to link the assault of 23 January, which prompted the transfer request, with the fatal assault of 28 January and we cannot conclude that consideration of a move was unreasonably delayed or that there was any reason to consider that the man was at immediate risk at that stage from anyone on his houseblock.

Events on the morning of 28 January

60. When the first prisoner discovered that property had been taken from his cell, the man’s cellmate told the first officer that he had the items. He denied that he had taken them, but said instead that he had received them from another prisoner who he did not name.

61. Later that morning, after another prisoner told officers that the man’s cellmate had concealed several improvised weapons around the wing and was intending to assault the second prisoner, the cellmate was moved to the segregation unit. The same prisoner also told officers that the second prisoner had said that he would kill the person who had taken his property.

62. The first officer told the investigator that he had recognised the possibility that the man might be at risk and said he reported his concerns to the wing SO and the Orderly Officer. Both of those officers denied this when the investigator spoke to them and with two directly contradictory accounts we have been unable to establish which version is correct.

63. At the time, officers were aware that the first and second prisoners were angry about the fact that their property had been taken from their cell. They knew their property had been in the man's cell so he at least must have been aware of it. In the circumstances we consider that the staff should have been aware that repercussions against the man were likely and taken action to protect him, especially as the cellmate had been removed from the wing. We make the following recommendation:

The Governor should ensure that concerns about the potential vulnerability of prisoners are properly recorded and considered and that any prisoner at risks of threats, intimidation of violence from other prisoners is appropriately protected.

Liaison with the man's family

64. The man was taken to hospital at around 3.00pm on the afternoon of 28 January but his family was not informed until approximately 5.30pm. Prison Rule 22, about the notification of illness or death, states:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury … the Governor shall … at once inform the prisoner's … next of kin …"

65. It was clear at an early stage that the man had received serious injuries. First contact with his family to inform them that he had been rushed to hospital should not have taken almost four hours. We make the following recommendation:

The Governor should ensure in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

66. The man's family were upset that prison escort officers remained in his hospital room until they asked them to move. It is usual for escort officers to accompany prisoners who are taken to hospital, but when prisoners are seriously ill we would expect a discreet presence. On the morning of 30 January, the Governor authorised that the one escort officer remaining at the hospital should move to a separate room away from the man which was appropriate.

67. The man's family were upset that when they visited the prison the Governor was not present despite the fact that the meeting had been pre-arranged. The Governor told the investigator that she had had to attend a hospital appointment with a family member that day. It was intended that the deputy governor would have delivered a letter of condolence from the Governor, but the meeting was fraught and this was not done. This led to a delay in the

letter being sent which should not have happened. The Governor subsequently wrote to the man's family to offer them a meeting to offer support or to answer any outstanding queries they might have. We consider that the Governor should have arranged the original meeting with the man's family at a time she was able to attend. We make the following recommendation:

The Governor should ensure that she is available to meet the family of deceased prisoners when they visit the prison.

Informing the police

68. We are concerned that the prison did not inform the police of the assault until two and a half hours after staff became aware of the incident. Although they would not have known at that stage that the man's injuries would prove fatal, it was apparent that he had been very seriously injured and that other prisoners were responsible. An emergency ambulance was called and the man was then taken to hospital. .We consider that once the emergency ambulance was called, the police should also have been informed.

69. The police were also concerned that important evidence was lost in the intervening period before they were called. It appears that the second prisoner was able to change his clothes and footwear and the originals were never found. The man had been found in the cell shared by the first and second prisoner and it should have been clear that there was a need to preserve evidence by securing the cell where the assault had occurred and isolating the prisoners involved in separate cells until the police arrived. We make the following recommendation:

The Governor should ensure that the police are informed without delay when a prisoner has been seriously assaulted, that all relevant evidence is preserved and that prisoners who could be under suspicion of the assault are held separately until the police arrive.

Securing cells and prisoner property

70. When the first and second prisoners left their cell on the morning of 28 January they were unable to secure it as they did not have keys for the cell door privacy lock. The first prisoner asked the first officer to lock the door and he said he would do it once all prisoners who were going to work or other activities had left the wing. In the meantime, another prisoner (or prisoners) was able to steal from the cell. This does not appear to have been an isolated incident at the prison and we know that the man was one of a number of prisoners trying to find missing property on houseblock six, a month earlier. The Prison Service has a duty to protect prisoners' property; the consequences in this case were extreme, but any failure to do so can lead to an unsafe environment. To avoid the risk of cell thefts, there is a need to ensure that prisoners either have privacy keys as intended, which allow then to secure their own property, or that officers lock cells when they are vacated. We make the following recommendation:

The Governor should ensure that all prisoners are issued with keys to lock their own cells and failing that, that officers lock cells without delay when prisoners leave the wing.

RECOMMENDATIONS

1. The Governor should ensure that prisoners are separated when there is information to suggest that a prisoner might be at risk of harm from his cell-mate.

2. The Governor should ensure that concerns about the potential vulnerability of prisoners are properly recorded and considered and that any prisoner at risks of threats, intimidation of violence from other prisoners is appropriately protected.

3. The Governor should ensure in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

4. The Governor should ensure that she is available to meet the family of deceased prisoners when they visit the prison.

5. The Governor should ensure that the police are informed without delay when a prisoner has been seriously assaulted, that all relevant evidence is preserved and that prisoners who could be under suspicion of the assault are held separately until the police arrive.

6. The Governor should ensure that all prisoners are issued with keys to lock their own cells and failing that, that officers lock cells without delay when prisoners leave the wing.