A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of man in February 2011, while a prisoner at HMP Full Sutton

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 of a man. The man died at HMP Full Sutton on 22 February 2011. He was 39 years old. Another prisoner was subsequently convicted of his manslaughter.

The investigation was carried out by an investigator and assistant investigator. A clinical reviewer carried out a review of the clinical care provided to the man. Full Sutton cooperated fully with the investigation. This investigation was suspended while the police carried out their investigation and I apologise for the consequent delay in publishing this report.

The man had been sentenced to life imprisonment in January 1994. He had been at Full Sutton since May 2007. The prisoner was also serving a life sentence and had been in Full Sutton since June 2010. On the evening of 22 February 2011,the prisoner barricaded himself and the man into a prison cell. When staff gained access to the cell, the man was unresponsive. Healthcare staff and paramedics tried to resuscitate him, but without success and it was established that he was dead. The prisoner was subsequently charged and tried over the man's death. He was convicted of the attempted murder of another prisoner and the manslaughter of the man, and sentenced to life imprisonment.

On the night that the man was killed, prison staff received intelligence from different sources that the prisoner had a weapon and intended to attack a sex offender on the wing. Although the prisoner was kept under close observation, this did not prevent the attack. I am concerned that prison staff did not proactively intervene once this intelligence was available. Indeed, staff appear to have had remarkably little knowledge of the significant risks the prisoner presented, especially as less than a year previously he had attempted to kill a notorious sex offender at another high security prison.

The investigation identifies a need to improve information handling about risk and the assessment of intelligence, particularly when dealing with such dangerous prisoners. Similarly, there is a need for consistent safe practice when unlocking cell doors to prevent prisoners locking themselves or others in. More generally, as identified in another recent homicide investigation, I am concerned that high security prisons lack a clear strategy about how to manage prisoners in vulnerable prisoner units who are themselves a serious risk to other vulnerable prisoners.

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 **February 2015**

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SUMMARY

1. The man had been in prison since 1994, serving a life sentence for the sexual murder of a child. The prisoner who murdered the man had been in prison since 2002, serving a life sentence for armed robbery. The man and the prisoner both lived in the same wing in Full Sutton. Both had been designated as vulnerable prisoners and were in one of the separate units housing these prisoners.

2. The prisoner had been transferred to Full Sutton after a serious attack on a prisoner convicted of the sexual murders of children in a vulnerable prisoner unit in HMP Frankland. After the attack, he had been held in Frankland's segregation unit. When he transferred to Full Sutton in June 2010, his status as a vulnerable prisoner was not reviewed. His cell sharing risk assessment when he arrived at Full Sutton made no reference to the attack in Frankland. At a sentence planning review in December 2010, after he had been charged with attempted murder for the attack in Frankland, his risk to other prisoners was described as low.

3. On 17 February, the prisoner and a friend, were suspected of bullying a third prisoner. They were monitored under Full Sutton's anti-bullying strategy. On 21 February, his friend assaulted another prisoner and moved to the prison's segregation unit. Staff were aware that this had upset The prisoner.

4. During evening association at about 5.45pm on 22 February 2011, a prisoner told an officer that the prisoner was planning to attack someone, possibly a sex offender. The wing manager informed the duty governor and the prisoner was monitored on the wing's CCTV equipment. Wing officers were made aware of the threat and told to keep a watch on him. At 6.28pm, another prisoner then told another member of staff, who was aware of the prisoner's history at Frankland, that the prisoner was carrying a weapon. The wing manager and the duty governor discussed how to deal with this further intelligence, but did not contact the security department or speak to the prisoner. The duty governor said in interview that he was unaware of the prisoner' background at this point, so it seems that they did not discuss this. They were still considering their next steps when, at approximately 6.40pm, the prisoner went into a cell where the man was watching television with another prisoner. He ordered the other prisoner out and locked the cell door.

5. Prison staff talked to the prisoner and tried to persuade him to open the door, but he barricaded furniture behind it and blocked the observation panel. He tied the man up and then tied him to the bed. Trained negotiators were called, who tried to persuade the prisoner to open the cell. He refused and threatened to harm himself, the man, and anyone else who came into the cell. When he eventually agreed to come out of the cell, staff found the man unresponsive. Healthcare staff tried to resuscitate him, but without success. He was confirmed dead by a prison doctor, at 8.48pm.

6. On 5 October 2011, the prisoner was convicted of the manslaughter of the man and an attempted murder at Frankland, and sentenced to life

imprisonment. The trial judge recommended that he serve at least 20 years in prison.

7. There is nothing to suggest that the man was being bullied or was under any specific threat. Nor was there any evidence of any antagonism between him and the prisoner. It is impossible to say whether the man was anything other than a random victim on 22 February 2011.

8. The prisoner has a history of mental health problems, a history of violence and there were several pieces of intelligence relating to bullying and intimidation. When he moved to Full Sutton after a high profile assault on a sex offender, he retained his status as a vulnerable prisoner. He was not subject to a full risk assessment either before or after transfer and he was located on a wing with sex offenders at Full Sutton. We are concerned that the risk the prisoner posed to other prisoners was not treated seriously enough or shared sufficiently. This allowed a situation to develop which could have been avoided if wider intelligence had been shared.

9. This report makes eight recommendations. Five are to the Deputy Director of Custody for High Security Prisons, relating to: information sharing between prisons when arranging transfers of high risk prisoners; the appropriate assessment of prisoners risks taking into account all known information; the reviewing of vulnerable prisoner status in light of significant events; the development of a clear national strategy regarding the management of prisoners in vulnerable prisoner units; and the operation of agreed and consistent safe practice when unlocking cell doors. A further three are to the Governor at Full Sutton: concerning appropriate risk assessment when there is credible intelligence of violence; ensuring there are well practised local contingency plans for hostage incidents; and emergency procedures that allow ambulance staff prompt access to prisoners.

THE INVESTIGATION PROCESS

10. The Ombudsman's office was informed of the man's death on 22 February 2011. Two investigators visited Full Sutton on 1 March 2011. They met a number of people, including the deputy governor and the manager who was the duty governor on 22 February. They were shown around the prison, including D wing, where the man lived and the command suite from where the response on 22 February was directed. Full Sutton provided copies of the man's prison and medical records. The investigator also obtained the prisoner's prison records.

11. Humberside Police conducted an investigation into the man's death. The Ombudsman's investigation was suspended while the police completed their enquiries and the case came to trial. The investigator remained in contact with the police throughout, and the police provided copies of their records and statements.

12. Once the criminal trial was complete in October 2011, the investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact him. Two prisoners provided some background information about Full Sutton.

13. East Riding of Yorkshire Primary Care Trust (PCT) commissioned a clinical reviewer to undertake a review of healthcare issues involved in the investigation. The clinical reviewer was given copies of the man's medical records. The prisoner refused permission to access his medical records, as is his right to do and made it clear he did not wish to cooperate with the investigation.

14. The investigator and another investigator, interviewed staff and prisoners in November 2011. After receiving further information, the investigator interviewed a former Full Sutton prisoner in September 2012. The investigator provided verbal and written feedback to Full Sutton during the investigation.

15. The National Offender Management Service (NOMS) conducted an internal enquiry into the events of 22 February 2011. Their report was made available to the investigator. This made a number of recommendations, some of which are covered in this report, while others addressed wider issues outside the scope of this investigation. NOMS received a copy of the draft report and their response to the recommendations is appended to this report. They also raised some questions that do not impact on the factual accuracy of the report, and these have been addressed in separate correspondence.

16. HM Coroner for East Riding and Kingston upon Hull was informed of the investigation. The Coroner provided the results of the post-mortem. A copy has been sent to the Coroner.

17. One of the Ombudsman's family liaison officers contacted the man's mother, outlining the purpose of the investigation and inviting her to identify any

relevant issues she wished the investigation to consider. Two investigators and one of our family liaison officer met the man's mother and her legal representative. They asked the following:

- Whether there had been any previous interaction between the man and the prisoner?
- What was the regime on the wing during association?
- What was the process of locking and unlocking cell doors?
- What consideration had been given to the prisoner's and the man's location and management?
- What risk assessments had been made?
- What was the procedure for cell searches?

18. The man's mother received a copy of the draft report. The solicitors representing her wrote to us pointing out some omissions and the report has been amended accordingly. They also raised 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.

19. In the course of the investigation, the investigator considered a large number of documents. Many of these documents contained minor discrepancies about timings. Some of the times noted will have been from people's own watches or a prison clock that was visible to them, which would not been synchronized. Not everyone noted the actual time, so in later statements used estimates. We have used the timings in this report likely to be the most accurate.

20. The investigation was suspended for some time until the outcome of court proceedings against the prisoner and then was a complex and lengthy investigation to undertake. We apologise for the consequent delay in publication of this report.

HMP FULL SUTTON

21. Full Sutton is a purpose-built maximum security prison. It holds up to 608 category A and B prisoners serving a minimum of four years. Healthcare services are commissioned through the East Riding of Yorkshire Primary Care Trust. There are registered general and mental health nurses, as well as a nurse prescriber (a nurse who is qualified to prescribe medication) and daily GP cover.

Vulnerable Prisoner Units (VPUs)

22. Full Sutton has three wings dedicated to housing up to 324 vulnerable prisoners separate from the rest of the prison population. Prisoners can be designated as vulnerable under Prison Rule 45 for a number of reasons which requires them to be kept separately. Reasons include:

- Committing an offence of which other prisoners disapprove (for example, sexual offences or one involving a child);
- Accumulating debts to other prisoners they are unable to pay;
- Giving evidence to the prosecution or being regarded as an informer; or
- Susceptibility to bullying from other prisoners.

D wing

23. D wing is one of Full Sutton's vulnerable prisoner wings, holding up to 108 prisoners. All cells are single and are on two storeys. The wing is a square of four corridors and on each floor three sides (called spurs or landings) contain cells. These spurs are called A, B and C. The fourth corridor contains rooms set aside for storage, administrative tasks, and meetings. The main staff office, where the senior officer is based, is on the second level on the corner between the administrative corridor and 2A landing. This office contains monitors for the CCTV cameras, which cover the corridors and association areas on the wing. CCTV cameras do not cover the inside of cells.

Daily regime on D wing

24. Prisoners are unlocked from their cells at 8.00am, for breakfast. Prisoners with jobs off the wing are taken to their workplaces from 8.20am. Prisoners without jobs are locked back in their cells. Prisoners return to the wing from their activities at approximately 11.15am, when non-working prisoners are unlocked. Lunch is served from 11.40am until 12.10pm. Prisoners then go back to work or back to their cells at 1.45pm. Working prisoners return at 4.10pm, and non-working prisoners are unlocked at 5.00pm, having freedom of movement around the wing including each others' cells. They remain unlocked until 7.10pm.

Anti-bullying strategy

25. When bullying is suspected, prison staff are expected to follow Full Sutton's anti-bullying strategy. Suspected perpetrators are subject to extra monitoring for a specified period, after which the situation is reviewed. If required, the process can be repeated as often as is necessary.

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a Caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is responsible. The ACCT plan should not be closed until all of the actions on the Caremap have been completed.

Incident command

27. When a prison faces a serious incident, the management structure is divided into three. The member of staff in charge at the site of the incident is designated the Bronze Commander. They will report to the Silver Commander, usually the most senior manager in the prison. The role of Silver Commander is to take overall command of the incident within the prison with the aim of bringing it to a timely, safe and successful conclusion. He or she must ensure that plans for surrender, intervention, containment and evacuation are drawn up and approved by the Gold Commander. This will be a senior member of the National Offender Management Service who is operating as the national co-ordinator. The Gold Commander's role is to provide overall, service-wide command of a serious incident, ensuring that tactics employed are in line with national policy.

Command suite

28. The command suite is a large office designed to allow staff to manage serious incidents. Located separately from the wings, it contains copies of policy documents, communication equipment and other material that might be needed in the management of various situations.

29. Prison Service Order (PSO) 1400 sets out mandatory actions and guidance for managing serious incidents. Full Sutton followed the national policies and plans and did not have a separate local incident management manual.

Her Majesty's Inspectorate of Prisons' (HMIP)

30. The last report published on Full Sutton by HMIP followed an announced inspection in December 2012. The report concluded that the prison:

> "is generally an impressive establishment that maintains an effective balance between providing the necessary levels of security and affording the men it holds decent treatment and conditions … although some longstanding concerns remain, this inspection found it had improved further."

31. In relation to violence reduction, the report said:

> "Prisoners' perceptions of their safety were comparable with other high security prisons. The systems to evaluate risk and monitor violence were very good overall … The number of recorded fights and assaults was low for the size and nature of the prison and had reduced considerably since the last inspection.

Independent Monitoring Board (IMB)

32. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB report for Full Sutton was the annual report for the year ending 31 October 2012. The Board commented that they were impressed with the progress made by the prison.

Previous deaths at Full Sutton

33. Since the Ombudsman's office took over responsibility for investigating deaths in prison custody in 2004, nine prisoners had died in the custody of Full Sutton before the man. Of these, six died of natural causes, two were apparently self-inflicted, and one death resulted in a prisoner being convicted of murder. There have since been nine further deaths, eight of which were from natural causes. Although one of these deaths had similarities to the circumstances in which the man died, previous reports from this office have not contained any recommendations which are relevant to this report.

KEY EVENTS

THE MAN

34. The man was born on 24 March 1972. On 28 January 1994 he was convicted of the sexually motivated murder of a child and sentenced to life imprisonment. The man spent time in a number of prisons. Reports indicated that at various times he had threatened to take his own life, was treated for depression, and was found to be in possession of drugs. He sometimes said he wanted to understand better what led him to offend. In 1995, while at HMP Frankland, the man was stabbed. There were reports of him being bullied, and on more than one occasion he was placed on support measures for those thought to be at risk of harming themselves[1]. At one point he was found to be in possession of home-made weapons. There were also notes relating to assaults on staff. The man was gay and had had relationships with other prisoners.

35. In 2003, the man was transferred to hospital under the Mental Health Act for a psychopathic disorder. After spending just over a year in Broadmoor Hospital it was decided that there was no effective treatment for his condition. He therefore returned to the prison and went to HMP Whitemoor.

36. In May 2007, the man transferred to HMP Full Sutton. Reports showed that he accepted responsibility for his offending and was willing to undertake work to address it. Security reports indicated he had problems with other prisoners, and incidents of him being bullied and having things stolen were reported. The man told various members of staff that he was concerned for his safety a number of times. Measures were taken under the anti-bullying strategy, which resulted in increased levels of observation and reviews of his situation. This had last happened in October 2009, when no evidence was found to substantiate the man's fears. Although he could be withdrawn, there were also times when the man was seen to fully engage with activities on the wing. He had to take some time off work in 2009 due to a problem with his ankle. He had also been diagnosed with high blood pressure. Otherwise, he had no serious health complaints.

37. The man was mentioned by name and his offence was referred to in a book by a well-known former prisoner which was published in 1999. The book implied that the man would be attacked in prison. A copy of this book was in the library at Full Sutton, and had been borrowed by other prisoners. It had not been issued to the prisoner.

[1] Known as Assessment, Care in Custody and Teamwork, or ACCT

THE OTHER PRISONER

38. The prisoner was born on 17 August 1975. He had behavioural problems as a child and was brought up from the age of seven by his grandmother. Records show that at the age of 12, the prisoner was attacked and sexually abused by an older boy. He had a number of previous convictions, some of which were linked to drug use. He was sentenced to life imprisonment in September 2002 for armed robbery.

39. During his sentence the prisoner spent time in a number of prisons. He had been found guilty of numerous breaches of Prison Rules, including possessing unauthorised articles, abusive and threatening behaviour, testing positive for drugs, fighting, destroying property, not complying with orders, and tattooing himself. There were intelligence reports about his involvement in bullying, trading drugs, and threatening other prisoners. He was monitored under ACCT procedures on several occasions as he was at risk of self-harm, and had cut his own face and arms a number of times as well as scalding himself. The prisoner declined to allow our investigation access to his medical records. Nevertheless, his general prison files refer to a long history of contact with mental health teams in prison.

40. In February 2006, his grandmother who had brought him up died. The prisoner was allowed to go to the funeral under escort, but arrived late. A family member later told the police that the prisoner found the death of his grandmother very traumatic. This appeared to have a detrimental effect on his mental health.

41. In 2007, while the prisoner was in HMP Long Lartin, reports indicated that he was involved in drug taking, and had amassed large debts. He was working with the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team to address his drug issues. A psychology report in March 2007 suggested that he might have an antisocial personality disorder and a generalized anxiety disorder, with mild symptoms of depression and a depressive personality disorder. He showed some evidence of aggressive traits, but a clinical intervention would be needed for more exact diagnosis. He also reported some symptoms which could be related to substance abuse or could have been an indication of a bipolar disorder.

42. In August 2007, at Long Lartin, the prisoner was moved to the segregation unit after writing graffiti saying “kill the nonces” and “scum” on a wall in a communal area. A cell sharing risk assessment in May 2008 judged the prisoner to present low risk of violence towards a cellmate. He seemed to be having trouble coping on an ordinary prison wing, and on two occasions cut himself. He was placed on ACCT support, and that month was designated as a vulnerable prisoner. He was transferred to the Vulnerable Prisoner Unit.

43. In April 2009, the prisoner transferred to HMP Frankland. In August of that year, he disclosed to a psychologist his childhood sexual assault, which he said had affected him badly. It was noted that he could sometimes demonstrate severe emotional instability and strong fluctuations in mood. He

had been refused a transfer to the therapeutic regime at HMP Grendon because of the number of disciplinary offences against him. In September, a note on his sentence file expressed concern that his being on a vulnerable prisoner unit limited his access to offending behaviour programmes.

44. A note of 7 September 2009 on the prisoner's prison education record stated that he was "very dangerous to staff". The note referred to him as a hostage taker and that no contact should be on a one-to-one basis. This is the only mention of the prisoner as a hostage taker and there is no information to show how this judgement was reached.

45. Records show that, through late 2009 and early 2010, the prisoner continued to be unpredictable. His mood fluctuated, he often reported sick, and at times appeared to be under the influence of drugs. He was punished for fighting, as well as for refusing to work and for throwing his television set. He also cut his face and arms. He was supported under ACCT procedures and, on one occasion, he cut himself and wrote on the walls in his own blood. The Parole Board considered the prisoner's case in March 2010 and considered that he needed to undertake offending behaviour work to address his risk factors, including violence linked to emotional control, use of instrumental violence, and substance misuse.

46. On 21 March 2010, the prisoner seriously assaulted a prisoner who had been convicted of the high profile murder of two children. The prisoner seriously injured the other prisoner's throat, using a home-made weapon.

47. After this attack, the prisoner was held in the segregation unit (an area of the prison where prisoners are separated from others, either for their own protection or for the good order of the prison). While he was in the segregation unit, he converted to Islam. A note on the prisoner' risk management file shows that, while he was in the segregation unit, he asked how many violent offences he would have to commit to be considered for the Close Supervision Centre (CSC) system[2].

48. The prisoner transferred from Frankland segregation unit to Full Sutton on 29 June. His cell sharing risk assessment (CSRA) was completed on the basis of verbal answers from the prisoner without reference to his files or previous documented history. The assessment did not refer to his recent attack on the prisoner at Frankland and merely noted "locate as normal". On 5 July, he was placed on ACCT support, after he had hit himself in the face, banged his head against the wall, attempted to cut his arms, and tried to hang himself using bed sheets. The following day he was relocated to the healthcare centre for a period of detoxification (without the prisoner' medical records we can not say from what). At the end of July he assaulted a nurse.

49. On 2 August, the prisoner moved from the healthcare centre. Because he had been in the healthcare centre since shortly after arriving in Full Sutton, he

[2] The CSC system is part of the national strategy to control and support problematic and disruptive prisoners

went to G wing, the induction wing, which ran parallel regimes for vulnerable and mainstream prisoners. There had been press reports of the prisoner's assault on the prisoner in Frankland and other prisoners were aware of who he was. While on G wing, the prisoner referred himself to the psychology department. He also handed in a home-made weapon. He told staff that he had problems with two other prisoners on the wing, stemming from their time at Frankland. When he was told he would be moving to B wing, one of the prison's wings for vulnerable prisoners, he threatened to harm himself to stop the move. He asked to be moved to the segregation unit. He refused to attend his ACCT review on 23 August and, the next day, he moved to B wing.

50. In September, the prisoner cut himself using broken glass. He was treated in the healthcare centre. A few days later, staff received information that the prisoner was in possession of a weapon and planned to assault another prisoner. The wing staff monitored him closely, but there were no incidents. The prisoner said he would be interested in taking part in offending behaviour courses. In October, he had a disagreement with another prisoner while playing pool and overturned the table. Four days later, he cut his arms and was again placed on ACCT support. On 28 October, in protest at not receiving his full canteen[3], he told staff that he would assault another prisoner, making explicit reference to repeating his serious assault on a prisoner in Frankland. The following week, he re-opened a wound on his face.

51. In October and November, the prisoner's security category was reviewed to consider whether he should be recategorised from B to C. It was decided that he should remain a category B prisoner. The reasons given were, because he had a history of self-harm, there were recent adjudications against him, and that his aggression and unpredictable behaviour indicated that he still presented a high risk. He was encouraged to work with mental health services and engage with offender behaviour programmes. At a sentence planning review[4] on 25 November, the prisoner said that, as he had been charged with attempted murder for his attack on another prisoner in Frankland, he expected to receive a further life sentence. The review concluded that his main objective was to continue working with mental health services towards a sustained period of stability. He was also set an objective to avoid warnings and adjudications, and was advised to be more selective in the company that he kept. At neither review was his status as a vulnerable prisoner considered.

52. On 14 December, his sentence plan was signed off noting his recent charge of attempted murder. Despite this, he was recorded as a low risk of harm to other prisoners.

53. The prisoner worked in the textile workshop at Full Sutton. At the end of December, he told a member of staff that he felt anxious when using scissors as he felt a temptation to stab someone. He did not specify a particular person. An entry in the wing observation book noted that the prisoner was

[3] Prisoners can order small personal items of shopping from a canteen list
[4] to ensure that the best possible decisions are taken in regard to the prisoner's needs and issues of risk

suffering from mental health problems, and should not attend work until further notice.

54. In January 2011, the prisoner was found to be in possession of heroin. He asked about being put onto offending behaviour courses, but was told that this was still under consideration. On 30 January, he moved to D wing, the vulnerable prisoner wing where the man lived. He was allocated cell 11 on landing D2A, on the second floor.

55. On 16 and 17 February, it was suspected that the prisoner and another prisoner, who was a close friend of his, were bullying a third prisoner for his tobacco. All three prisoners insisted that they were friends and that bullying was not an issue. As a precaution, anti-bullying procedures were begun. The prisoner and his friend were subject to extra monitoring for a period of seven days, after which the situation would be formally reviewed. During the night of 17 February, the prisoner handed a piece of broken glass which he had in his cell to a member of night staff to stop him from harming himself with it.

56. On 21 February, his friend assaulted someone and was moved to the segregation unit. The prisoner seemed very upset about this.

Relationship between the man and the prisoner

57. After the prisoner moved to D wing, staff were not aware of any association between him and the man. A prisoner who knew them both and was a friend of the man's, said that the prisoner occasionally come into his cell while the man was in there, and the two had briefly exchanged small talk. There did not appear to be any animosity between them. When interviewed by the police after being arrested, the prisoner said that he only knew who the man was from being on the same wing, and that he did not often speak to him.

Tuesday 22 February 2011

58. On Tuesday 22 February, the man went to his work in the Braille unit at Full Sutton as usual. His friend saw him during the day, and later told the police that the man seemed to be his normal self. That afternoon the man did not return to work as he had a sentence planning meeting with his offender supervisor.

59. The offender supervisor said that the man was quiet and withdrawn, and did not associate with many other prisoners. During the meeting the man said he felt that other prisoners disliked him because of his offence. He said that he felt anxious and depressed, and unable to cope. He did not give any specific details of individuals who did not like him or of actual threats. The meeting set targets for the forthcoming year.

60. At 5.00pm, D wing prisoners were unlocked for association[5]. The wing contained 103 prisoners. During association it was supervised by a senior

[5] free time for leisure activities and socialising

officer and 13 prison officers. The man's cell was on landing 1C on the first floor. This area is known as a drug-free area (part of a prison initiative to help prisoners who wish to stay away from drugs). Prisoners volunteer to stay there, and have regular voluntary drug tests. Other prisoners are not allowed onto this landing, but prisoners from 1C can visit prisoners on other landing cells. The man had therefore gone up to landing D2A on the second level to visit his friend in cell 14. The man's friend estimated that he arrived at approximately 5.45pm.

Intelligence about the prisoner

61. At approximately 5.45pm, a prisoner told an officer that the prisoner was intending to attack someone. (CCTV footage showed this prisoner and the prisoner talking together a few minutes before.) He said that the prisoner wanted to be moved to the segregation unit so he could be with his friend. He said that he was lost without him, describing him as his "right hand man". The prisoner said that the prisoner had appeared to be angry about this. The prisoner did not say who the prisoner was intending to attack or whether it was anyone specific, but he did say that the prisoner said he was going to "badly" attack a "nonce". At 5.50pm the officer telephoned a Senior Officer (SO) in the staff office on the second floor, and told him what he had heard.

62. The SO who was aware that the prisoner had attacked another prisoner in Frankland, telephoned each staff office on D wing and asked for all members of staff on the wing to be made aware that the prisoner should be watched. The wing is covered by CCTV but cells are not. The SO asked staff to pay particular attention to the prisoner if he went into a cell. He then contacted the duty governor. The duty governor was patrolling the prison at the time. He went to D wing to discuss with the SO how to respond to the intelligence. He arrived in the second floor office and joined the SO at 6.08pm. He ensured that wing staff were aware of the information, and that a note had been made in the wing observation book. The duty governor was not aware of the prisoner's attack on another prisoner in Frankland.

63. The wing office contains the monitors from the wing's CCTV cameras. The duty governor and the SO watched the prisoner on the screens, and he appeared to be behaving calmly. They agreed that staff should keep a close presence and also monitor the prisoner through the CCTV cameras. The duty governor said in his police statement that there was not enough intelligence at that stage to justify removing the prisoner from the wing.

64. The man's friend said that he noticed that staff were patrolling the landing more frequently than was usual. An officer saw the prisoner on landing 2B, going in and out of other cells, which is normal for prisoners during association periods. The prisoner asked the officer why staff were watching him. He was not aggressive and the officer did not notice anything untoward in his manner.

65. At 6.28pm, another prisoner told an officer that the prisoner was carrying a weapon and intended to attack a "nonce". The officer passed this information

on to the SO, although the SO did not recall that he mentioned the threat being specific to sex offenders. The SO and the duty governor were discussing how to respond to this further intelligence when they saw the prisoner on the CCTV monitor walking towards the gate by the office at the end of D2A landing. The officer who was aware of the intelligence about the prisoner was by the gate when the prisoner approached. She spoke to him and he told her that he was bored. She suggested that he go to his cell and watch television. He agreed that he would return there and have a cup of tea. This was at 6.38pm.

66. The prisoner then turned and walked back up the corridor. The officer saw him pause outside the cell of another prisoner and have a short conversation. He stepped briefly into the cell, then came out and continued to walk along the corridor. CCTV stills do not show any staff on the corridor at that time. The duty governor and the SO continued to monitor him on the CCTV screens, and saw him go into his friend's cell.

67. The man's friend was still in his cell with the man. When the prisoner came in the man's friend did not initially think anything of it as the prisoner had come into his cell many times before. The man's friend said that he greeted the prisoner and he replied "Right, you've got an option. Out of your cell now, or you're dead". The man's friend took the threat seriously. He stood up and began to leave the cell. The man, who was sitting on the bed, also stood up but the prisoner pushed him back down with his left arm. At the same time he ushered the man's friend out of the cell with his right hand. The man's friend saw that the prisoner was holding an improvised weapon in his left hand made out of a sharpened piece of wood. As the prisoner ushered him out of the door, he pushed the door closed, which locked it.

68. When the SO saw the prisoner go into the man's friend's cell, he asked two officers to go and see what was happening. They were going towards the cell when the man's friend came out and the cell door slammed shut. When one officer reached the cell, the door was locked. The officer looked through the cell observation panel, but it had been covered with paper. The officer called to the prisoner, to move the paper so he could talk to him. The prisoner said that he was holding the man hostage, and if anyone tried to enter the cell or put a key in the lock, he would kill him.

69. The SO joined the officer at the cell door. The officer again asked the prisoner to remove the paper covering the observation panel so they could talk more easily. The prisoner did so, and the officers could see that he had moved a piece of furniture behind the door to barricade it. The prisoner was standing next to the man, who was sitting on a chair. The prisoner was holding the man's head and pressing a sharpened wooden weapon against his throat. He then covered up the observation panel again. The officer and the SO kept talking to the prisoner and asked about the man. The prisoner said that the man was okay and that he would not harm him.

70. The officer remained at the door, trying to maintain conversation with the prisoner, while the SO went back to the office and told the duty governor what

was happening. The duty governor informed the prison's control room that they had a hostage situation. He then ordered that prisoners on D wing be locked up and that the cells near the man's friend's should be evacuated. The SO helped officers lock the other prisoners into their cells. Prisoners whose cells were on 2A landing were taken into the wing association room. He then returned to the man's friend's cell. The prisoner had uncovered the observation panel again, and the SO could see that the man was still sitting in the chair. His hands were now tied behind his back and he had lengths of torn bedding around his neck. The prisoner later told the police that he had told the man to tie his own feet together, then the prisoner had tied his hands. The prisoner said that if anyone tried to come into the cell he would kill the man and kill himself or anyone else who came into the cell.

71. In case the prisoner was simply trying to effect a move to the segregation unit to be reunited with his friend, the SO told the prisoner that he could move him there immediately if he came out of the cell. The prisoner would not.

72. The prisoner told the police that he then told the man to move onto the bed. He then tied his feet to the bed and put a gag in his mouth. He tied three or four separate ligatures around the man's neck and secured them to the frame of the bed. He said that the man did not resist or struggle.

73. The control room contacted all staff who were needed and informed them of the situation. Members of the IMB who were in the prison at the time were told what was happening. After being informed that it was a hostage situation, two SO's went to D wing. Two nurses took an emergency medical bag and arrived on D wing at 6.56pm. The duty governor left the senior officers to oversee the situation from the office on D wing, and left the wing at 7.00pm to open the command suite, taking with him documents about both prisoners.

74. The Yorkshire Ambulance Service was alerted to the situation and at 6.59pm. Paramedic was asked to attend the prison as a first response, in case urgent emergency medical assistance was required.

75. A trained hostage negotiator was contacted at 7.00pm and asked to attend D Wing where it was agreed that he would be lead negotiator would act as collator, handling communications, and another officer would act as runner, passing information between them.

76. The SO and a negotiator continued to try to engage with the prisoner. The prisoner said that he knew how to kill someone else and himself. He said that he knew where the main arteries in the neck were. The SO and the officer asked for a response from the man, and to be able to see him. The prisoner said that he was going to have a cigarette and decide what to do. The officers continued to try to get the prisoner to speak to them. The SO looked through the gap between the door and the door frame and saw a pair of feet protruding over the side of the bed, as if someone was lying down. He heard choking noises and again asked if all was okay. He asked to speak to the man. The prisoner said that the man was fine. He said that he had tied and gagged the man, that he was going to have a cup of tea and watch television

and that he would give himself up at 8.00pm when the programme had finished. The SO asked the prisoner to give up his weapons, but the prisoner said that if he did, the staff would come into the cell. The SO assured him that this would not happen, but the prisoner would not give up his weapons. The SO was concerned that choking noises he could hear were the sound of the man being harmed by the prisoner. He went to the office to expedite the posting of the negotiating team and then returned to the cell.

77. The prisoner moved the paper covering the observation panel, which allowed the SO a restricted view of the cell. He saw that the man was on the bed with a ligature around his neck, the other end of which was tied to the bed. He could not see the man moving. The prisoner told the SO that the man 'was fine' but that he had gagged him. The prisoner told the SO that he himself had taken 30 paracetamol tablets. The SO then left the cell to brief the intervention team.

78. It was now approximately 7.16pm, and the officer went to the cell door to take up negotiations. He was brought up to date by the SO and the officer. As the observation panel was again obscured by paper he could not see into the cell. He began to try to engage with the prisoner and, after some initial reluctance, the prisoner began to talk to the officer. At this point the other officers withdrew. He told the officer that he would leave the cell at 8.00pm. While he was talking, the prisoner moved the paper from the observation panel. The officer saw the man lying on the bed but he could not see him moving. The prisoner started to tell the officer about the incident when he attacked the prisoner at Frankland. He said that before the attack he had received telepathic messages from the prisoner asking the prisoner to attack him. He said he had received similar telepathic messages from the man earlier that day, asking him to kill him due to the nature of his offence.

79. During this conversation the prisoner held a weapon to his throat and threatened to stab himself if the officer came into the cell. The prisoner talked about the unfairness of his friend being removed to the segregation unit. He also said that it was close to the anniversary of his grandmother's death. He was angry at the Prison Service for causing him to arrive late at her funeral.

80. At 7.16pm the first response paramedic arrived at the prison. He was briefed by staff, and waited at the main gate. An ambulance arrived at 7.22pm and also waited at the gate.

81. The officer was acting as the negotiator liaising between the officer at the cell and the officer in the office, although nobody had been in a position to collect the negotiators' grab bag on their way to the wing. Another officer overheard some of the conversation between the officer and the prisoner. At one point he heard the prisoner say "Don't worry about him, he's gone". The prisoner continued to threaten to harm the man if staff entered the cell.

82. The duty governor contacted the NOMS National Operations Unit at 7.24pm. Gold Command was established, with a senior manager to coordinate and the

duty governor was told that the National Tactical Support Group would be deployed to the prison.

83. The SO had returned to the cell and, at 7.26pm, the prisoner removed the paper blocking the observation panel. The SO and officer could see the man lying motionless, still tied to the bed.

84. An operational manager arrived at the prison at 7.30pm. He joined the duty governor in the command suite and confirmed that necessary contingency plans had been put into operation. One of the prison's control and restraint (C&R) commanders, had been called to D wing and was preparing surrender and intervention plans. Two C&R teams had been formed, designated as Team One (to ensure the prisoner's compliance with instructions) and Team Two (to ensure the man's compliance, if necessary). They were waiting on D wing in case they were needed, being briefed by the SO. The operational manager asked the SO for his assessment of the situation, who said that he had only had limited opportunities to see into the cell, but from what he had seen he thought that the man might be dead. He had asked to speak to him a number of times, but had received no response.

85. At some point between 7.36pm and 7.41pm, the prisoner told the officer that he had strangled the man. When the officer called to the man there was no response. The prisoner talked of taking his own life. He removed the paper covering the observation panel. He again said he would leave the cell at 8.00pm, when the television programme he had on would finish.

86. At 7.45pm, the officer was told that the prisoner had indicated he intended to surrender. The usual practice is for a surrender plan to be written and agreed by Silver and Gold command before any action is taken. However, as it looked likely that the prisoner was ready to surrender imminently, the officer telephoned the command suite and obtained verbal agreement from the duty governor to take his surrender. The officer then briefed the C&R teams on the surrender plan.

87. The deputy governor, arrived at the prison and, as the most senior member of staff, took over from the duty governor as Silver Command at 7.45pm. The duty governor told him that they could not ascertain if the man was dead or alive and that the prisoner had threatened to kill him if staff attempted to enter the cell. If the man were still alive, any such effort might put his life at risk.

88. The prisoner had indicated that he was ready to give up his weapons, and the officer opened the inundation point in the cell door[6]. At 7.50pm, the prisoner passed two improvised weapons out of the inundation point. He said that he wanted to surrender and would comply with any instructions. He told staff that he wanted to die. He said he had hidden glass in his anal passage. He said that he had cut the man's throat and had blood on him, though the officer could not see any evidence of this. The officer explained the exit procedure to

[6] each cell door has a circular panel, a few inches wide, which allows the insertion and use of a water hose should a locked cell catch fire

the prisoner. He reassured him that, if he complied with instructions, staff would not forcibly restrain him.

89. At 7.54pm, the ambulance staff entered the prison and, at 7.57pm, the C&R teams and healthcare staff went onto the landing and waited outside the cell. An officer spoke to the prisoner and gave him instructions about how to leave the cell. The door was opened and, at 7.58pm, the prisoner backed out with his hands above his head. He stepped to one side, supervised by C&R Team One, and was searched.

90. As soon as the prisoner left the cell, C&R Team Two went in. This team consisted of four officers. They could immediately see that the man did not present a threat and called for the nurses to come. The officer saw that the man had a number of ligatures around his neck, one attached to the frame of the bed. As he untied the ligatures, two officers moved the furniture in the cell, to allow the nurses more room to manoeuvre. As one of the officer untied the man's feet, another officer tried to cut the ligatures from the man's neck, but found this difficult as they were very tight. He noted that the man's nose and lips were blue and thought that he was dead.

91. A nurse and healthcare assistant (HCA) went into the cell within a minute of the prisoner leaving. One of the nurses called for a doctor and the ambulance staff. The officers removed furniture from the cell to allow the nurses more room to work. The nurse checked the man for signs of life, but was unable to find any. The nurse and The HCA told the investigator that it was clear to them that the man was dead. Nevertheless, they tried to resuscitate him. A defibrillator was used but did not advise shocks. Staff proceeded with cardiopulmonary resuscitation (CPR – a mix of rescue breaths and chest compressions to manually circulate oxygen around the body). At 8.00pm, the paramedics joined the resuscitation attempts.

92. Paramedics performed an electrocardiogram test (ECG – an electrical reading of the heart) and tried to insert tubes into the man's throat. However, his throat was damaged and they were unable to do so. The nurse cut the ligatures from the man's hands so that a tube could be inserted into the veins in his arms, but again this was unsuccessful. The paramedics and prison healthcare staff continued to try to revive the man until 8.21pm, when it was agreed that the man was dead. Staff then left the cell, which was sealed until the prison doctor, arrived at 8.45pm and officially pronounced the man dead.

93. After he left the cell, the prisoner was escorted to the segregation unit. An officer supervised a strip search. The prisoner was found to have hidden tobacco and matches on him but there was no evidence of any glass. A nurse found that the prisoner did not have any injuries. He was then located in a cell with a CCTV camera so that he could be observed.

94. While he was in the cell, segregation unit staff heard the prisoner shouting out that he had killed the man and giving details of what he had done. He was placed on ACCT support, as they were concerned that he might harm himself. The officer was detailed to keep him under constant observation. The officer

told the police that the prisoner was very talkative. He talked of general matters, then began to say that he hated sex offenders and spoke of his previous attack on a prisoner at Frankland. He said that he had told the man that he was going to kill him, and the man did not struggle but seemed to accept that. The prisoner told the officer that it had been a spur of the moment decision to kill the man.

Family Liaison

95. At the time, guidance to staff following a death in custody was contained in Prison Service Order (PSO) 2710 (now PSI 64/2011). This recommended that if someone dies in custody, their family should be informed face-to-face if at all possible. Due to the distance from Full Sutton, it was agreed with HMP Wormwood Scrubs that one of their trained family liaison officers should inform the man's mother, who was his next of kin. The family liaison officer went to the man's mother's home at 11.25pm. He informed her and her husband of the man's death. The family liaison officer explained that a family liaison officer from Full Sutton had been appointed and provided contact details.

96. A Senior Officer was appointed as Full Sutton's family liaison officer for the man's family. The next day he contacted the man's mother and explained that he would be her liaison from that point onwards.

97. The prison's Anglican chaplain contacted the man's mother to offer support. In line with Prison Service guidance, the prison offered to contribute to the costs of the man's funeral. With his family's permission, the prison was represented at the funeral.

98. A memorial service was held in the prison on 6 March 2011 to allow the man's friends and fellow prisoners the opportunity to pay their respects.

Staff Support

99. It is usual following the death of a prisoner to hold a debriefing session with staff involved in his or her care. These ensure that staff have an opportunity to discuss any issues arising and for support to be made available.

100. Debriefs were held in the prison. All staff involved were included. No specific issues were identified. Support was made available for staff and the staff care team attended the debrief.

Support for prisoners

101. The man's friend was given individual staff support. He was taken to the healthcare centre and monitored under ACCT procedures. After he left the healthcare centre, the man's friend was reintroduced to the main prison through the induction wing, to ease his way back in.

102. Prisoners in the cells around the man's friend's cell were reallocated. Due to pressures on space some were temporarily housed in the segregation unit, and some in the healthcare centre.

103. All prisoners subject to ACCT monitoring were reviewed. Listeners (prisoners selected and trained by the Samaritans to provide confidential emotional support for fellow prisoners) were briefed as were the local branch of the Samaritans in case they took any calls from prisoners. Prisoners were informed of the man's death by notices posted on each wing. The notices informed prisoners of the support that was available to them.

Post-mortem

104. A post-mortem examination was carried out at the Hull Royal Infirmary on 23 February 2011. The doctor concluded that the man's death was due to pressure of the neck. This had been caused by a ligature, possibly exacerbated by a gag. There was no evidence of any other pressure, such as hands, being used.

Toxicological report on the prisoner

105. The prisoner had some medical tests and a toxicology report was produced. The toxicology report concluded that at the time of the incident:

- he was not intoxicated through alcohol;
- he had taken a standard dose of ibuprofen, which would not have affected his behaviour;
- he had taken paracetamol. Although the level in his blood was higher than a standard dose, it was unlikely that he had taken as many as 30 tablets. It would not have affected his behaviour;
- he was not under the influence of any detectable drugs, illicit or otherwise, with the possible exception of cannabis.

Police investigation

106. Humberside Police carried out an investigation into the man's death and a criminal prosecution followed. The prisoner was jointly tried for the attack on a prisoner in Frankland and the killing of the man.

107. While awaiting trial, the prisoner was assessed by a number of psychiatrists and psychologists. They concluded that he was suffering from an abnormality of mind which was a significant contributory factor to his acts. In light of this, a plea of manslaughter on the grounds of diminished responsibility was accepted.

108. In October 2011, the prisoner was convicted of attempted murder (of a prisoner at Frankland) and the manslaughter of the man on the grounds of diminished responsibility. He was sentenced to life imprisonment.

Intelligence received after the man's death

109. As part of the police investigation, a number of intelligence reports from the days leading up to the man's death and from the following days were examined. Much of the intelligence contained facts already known. There were suggestions that the prisoner had planned the attack on the man and had a hatred of sex offenders. There were suggestions that other prisoners might have been aware of what he was planning. The police assessed the intelligence, and noted that the information before 22 February indicated that the prisoner was suspected of bullying and involvement in drugs, but there were no specific threats to the man. Intelligence in the days after 22 February was contradictory. This was mostly new information which had only been put forward in light of what had happened. The police assessment was that the information received afterwards was not credible but had been formed in light of events.

National Offender Management Service (NOMS) investigation

110. NOMS commissioned a review of events on 22 February, conducted by a senior manager. This was an internal review and was not published, but NOMS shared the report with the investigator.

111. The report concluded that there were some issues with the longer-term management of information about the prisoner and the risks he posed. There were also some questions about whether the response to the intelligence received about the prisoner on 22 February was proportionate to the risk identified. The report considered that the hostage situation was handled appropriately.

ISSUES

The prisoner's transfer from Frankland

112. It is not unusual for prisoners to move within the high security estate, of which Frankland and Full Sutton form a part. By their very nature, high security prisons deal with dangerous prisoners, a number of whom have been involved in assaults against other prisoners. Many have committed very serious offences some of which mean that they are regarded as vulnerable prisoners and need to be kept apart from others. We would not expect prisons transferring prisoners to have detailed discussions and briefing before every transfer. Movements of category A prisoners are preceded by contact between operational managers but the prisoner was not a category A prisoner.

113. Nevertheless, the prisoner's transfer from Frankland to Full Sutton followed a highly-publicised attack on a high-profile prisoner. This in itself would have presented issues that needed to be considered about his future management. However, the prisoner's entry on NOMS' computer records system did not refer to the attack he carried out in Frankland, or record that he had been held in the segregation unit there before his transfer. Because of the seriousness and notoriety of the events which led to the prisoner's transfer, it would have been helpful to the receiving prison if senior staff had discussed this in advance. We were surprised to be told that this did not happen. Discussions in advance would have allowed Full Sutton to have considered whether the prisoner presented any exceptional risk and how they would manage him. The NOMS internal investigation made a recommendation to Frankland that the population management team should communicate to the receiving prison, in advance, all relevant facts including details of heightened risks when managing transfers. We agree that information about specific risks and other relevant background information should be communicated before transfer. We make the following recommendation:

    The Deputy Director of Custody for High Security Prisons should ensure that whenever prisoners are transferred between high security prisons after alleged or proven acts of serious violence the sending prison provides a full account of events, the potential risks and any advice on how best the prisoner should be managed.

Assessment of the prisoner's risk to other prisoners

114. When he was held in the segregation unit at Frankland after his attack on a prisoner there, the prisoner asked how many violent offences he needed to commit to get into the Close Supervision Centre (CSC) system (where he now is). This would seem to indicate a possible intention or willingness to commit further violent offences. However, this did not trigger a review of whether he ought to have been considered for the system. Nor was his status as a vulnerable prisoner reviewed.

115. The deputy head of security said that, when prisoners are due to transfer to Full Sutton, an intelligence report should be forwarded by the sending prison before the prisoner moves. When the prisoner arrives they first go to the induction unit (G wing) and an activity risk assessment is completed to allow them to attend work, gym or religious services. A cell sharing risk assessment (CSRA) is completed, which is to assess the risk the prisoner is judged to present to any potential cellmate. Although cells at Frankland and Full Sutton are not shared, the assessment should identify those who are potentially dangerous for cell sharing and other occasions when space might be shared. Vulnerable prisoner status is not routinely reassessed.

116. The prisoner's CSRA noted that the prisoner had a history of aggression, but does not refer to the serious attack on a prisoner in Frankland which led to the transfer. Nor does it mention his status as a vulnerable prisoner. We would have expected the prisoner to be assessed as high risk, but this does not appear to have been done. In October 2010, while protesting against not receiving his canteen, the prisoner made explicit reference to repeating his earlier serious assault on a prisoner. His vulnerable prisoner status was not reconsidered at this stage, neither was his CSRA reviewed. We are also concerned that at his sentence planning review in December 2010, after he had been charged with attempted murder for the earlier assault, his risk to other prisoners was assessed as low. It is difficult to understand how that conclusion was reached.

117. Prison Service Instruction (PSI) 03/2010 notes that prisoners may be identified as category A prisoners during their sentence "if information comes to light to suggest the prisoner poses a potential risk that warrants the highest level of security category". One of the examples given is the prisoner is charged with a further serious offence. The prisoner, already serving a life sentence, was charged with attempted murder but when his security category was reconsidered it was only in the context of whether he should be lowered from B to C. There is no evidence of any consideration about a potential recategorisation to category A, which we think should at least have been considered.

118. The prisoner' Offender Assessment System (OASys[7]) evaluation was not reassessed after of his attack on another prisoner in Frankland. His offender manager (probation officer) agreed with her manager that as it occurred in custody it should not be treated as a serious further offence. We are concerned that a serious violent offence against another person should apparently be disregarded in this way because the victim was a prisoner and the offence took place in prison. Such use of violence is a clear indication of a potential future risk of harm. A sentence planning review was scheduled for 24/25 November 2010, but the offender manager was unable to attend. The prisoner' OASys should have been reviewed for this meeting, but because the meeting did not take place this did not happen.

[7] OASys is an electronic system used by prisons and the Probation Service to assess the risks offenders present on an ongoing basis.

119. The prisoner' records and history contain a number of indicators which should have caused serious concern about his risk to others. Some are more substantial than others. In Frankland, his serious assault on a high profile child sex offender alone should have identified him as a serious risk to other prisoners, at least to those who had committed sex offences and in particular sex offences involving a child. There were also other indicators of risk. In 2007, he was responsible for graffiti referring to violence against sex offenders. In April 2009, he revealed that as a child he had been sexually assaulted by an older boy and that this had affected him badly. In 2009, his education file noted that he was a hostage taker, although there are no other records which corroborate this. In an assessment for a course in December 2010, the prisoner professed a dislike of sex offenders against children and said that he chose to ignore them in prison. His record, in and out of prison, shows a history of bullying and aggression. While accepting that high security prisons contain many dangerous prisoners with a good deal of security history, it does not appear that at any stage all these indicators were considered together. We make the following recommendation:

The Deputy Director of Custody for High Security Prisons should ensure that all known information is taken into account when assessing prisoners' risk, including offences committed in prisons, and that this information is communicated to wing staff to inform their management.

The prisoner's status as a vulnerable prisoner

120. The prisoner had been designated as a vulnerable prisoner in May 2008 while at Long Lartin because he was said to have been having difficulties coping. It was not because of the nature of his offence. He had retained that status since that time.

121. The prisoner's access to his victim at Frankland had been possible because the prisoner had been classified as a vulnerable prisoner. At Full Sutton he went to the vulnerable prisoner unit automatically because he had previously been regarded as a vulnerable prisoner. There was no reassessment of his vulnerable prisoner status or risk to other prisoners after his move to Full Sutton despite his acknowledged animosity towards child sex offenders demonstrated by the serious attack at Frankland. The prisoner's vulnerable prisoner status was not reassessed at that time.

122. There is no national policy on reviewing a prisoner's status as a vulnerable prisoner. The investigator requested some information from the intelligence unit at Full Sutton on vulnerable prisoners. He was told that:

> "Prisoners arriving at Full Sutton are risk assessed on an individual basis, taking into account their index offence, previous convictions, gang affiliations, any history of self harm/suicide and custodial behaviour. Any prisoners transferring into Full Sutton that have previously been risk assessed as being a vulnerable prisoner at

another establishment would be assessed prior to location on a VP wing at Full Sutton".

123. In interview, however, the deputy head of security and operations said that when a prisoner arrives at Full Sutton designated as a vulnerable prisoner, that status is not automatically reassessed before allocating them to a VP wing. There is no evidence to show that the prisoner's status was reassessed on or after arrival at Full Sutton.

124. Many vulnerable prisoners have been convicted of sexual offences against children. On 22 February 2011, there were 103 prisoners on D wing at Full Sutton. Over half of these were regarded as vulnerable prisoners because of the nature of their offences. We are concerned that, without any apparent consideration of the potential risks, the prisoner was still housed on a vulnerable prisoner unit with access to such prisoners despite having carried out a serious attack on a child sex offender.

125. We believe there should have been a fully considered review of the prisoner's vulnerable prisoner status after the Frankland attack. It would be sensible to review vulnerable prisoner status whenever there is an indication that a vulnerable prisoner is a particular risk to other vulnerable prisoners. We accept that it is entirely possible that a review would have considered the circumstances and decided that the prisoner still remained vulnerable. If that were the case, a management plan should have been drawn up to manage the risk, but the absence of an overarching strategy to deal with such circumstances is troubling, particularly as other recent homicides in high security prisons also suggest this is a problem. We make the following recommendations.

The Deputy Director of Custody for High Security Prisons should ensure that vulnerable prisoner status is reviewed periodically and reassessed in light of significant events which indicate the prisoner is a particular risk to other vulnerable prisoners.

The Deputy Director of Custody for High Security Prisons should develop a clear strategy to manage prisoners in vulnerable prisoner units who themselves are a risk to other vulnerable prisoners.

Mention of the man in a book in the prison library

126. A former prisoner published a book in 1999 that refers to the man and his offence. A copy of the book, which contained an implication that the man would be attacked in prison, was in Full Sutton's library.

127. It is unlikely that this played a part in what happened. Records show that while the book had been loaned by prisoners on nine occasions, the prisoner was not listed among them. Prisoners have access to a wide range of literature and information, including from mass media. By the nature of their crimes, information about many prisoners and their offences are in the public domain. It would not be reasonable to expect prisons to be able to restrict

such information. Even if they did, prisoners could easily obtain details of other prisoners' offences through friends and family.

Response to the intelligence about the prisoner on 22 February

128. When a member of staff was first told that the prisoner was planning to assault a prisoner the intelligence was not specific, with no individual prisoner mentioned as the target. The member of staff reported it to his senior officer, who immediately made other staff aware of the threat. He asked staff to pay particular attention if the prisoner went into cells, which were not covered by CCTV. He then reported it to the duty governor.

129. Statistics show that in 2010-11 Full Sutton had between 500 and 700 security information reports (SIRs[8]) per month. Security reports are sent to the security department, where they are assessed in conjunction with other relevant security information. Up to a quarter of these were threats of violence. Many remained just threats. Sometimes the reports were malicious, with prisoners wanting to point suspicion at other prisoners.

130. The duty governor, the duty governor, said that on that initial piece of information he decided not to contact the security department immediately. It was a single strand of intelligence, of a sort that was not unusual. The duty governor said in his police statement that there was not enough to substantiate intervening with the prisoner at this time to remove him from the wing. Instead it was agreed that the prisoner would be monitored on the CCTV screens, and staff presence was increased to the extent that the prisoner and the man's friend both noticed.

131. We consider that this was a reasonable initial response, but only because the duty governor said he was unaware of the prisoner's highly publicised attack on a vulnerable prisoner at Frankland less than a year earlier. It is a serious concern that this incident was not clearly noted on the prisoner's record and readily available to officers. Once these measures were in place, there was an opportunity to assess whether there was any further intelligence on the prisoner. He was still being managed under the anti-bullying strategy, and a friend was being held in the segregation unit for an assault. Wing staff knew the prisoner to be upset about this. This was a missed opportunity to assess the prisoner further and build a fuller picture of the overall circumstances.

132. When more intelligence came through from a different prisoner, shortly afterwards, that the prisoner was thought to be carrying a weapon, the SO and the duty governor were still in the office on D wing. They discussed how to deal with this further intelligence and considered options such as whether to challenge him, take him back to his cell, take him off the wing and search him, or remove him to the segregation unit.

[8] Any member of staff is encouraged to record any piece of information on a prisoner. This is then evaluated by the security department on factors including how reliable the source and the potential impact on security if it is true.

133. The duty governor said that, had the prisoners been locked in their cells when intelligence about a weapon came through, the usual action would be to carry out a planned removal of the prisoner, who could then be searched. However, he decided that as all prisoners were out on the wing for association, challenging a prisoner risked a confrontation that could escalate. Staff to prisoner ratios are low when all prisoners are unlocked and staff were not ready to deal with such a scenario at short notice. Prisoners were due to be locked away at 7.10pm, just over half an hour later. Furthermore, if the prisoner was planning an attack, staff felt that calling him to the office might have aroused his suspicions and prompted him to attack someone immediately. The intelligence had not been evaluated: one member of staff told the police that the prisoner who provided the second strand of intelligence was an unreliable source of information. There was no threat to a specific person. It remained a possibility that the prisoner just wanted to be moved to the segregation unit to be with his friend. With prisoners due to be locked away fairly soon, The duty governor decided that the best thing to do was to wait until the prisoners were in their cells, then arrange a planned removal of The prisoner and conduct a search, of him and his cell, for any weapons.

134. At this stage, it was still not known how reliable the information was. However, there were now two separate strands of intelligence relating to the same prisoner. There was information that he was possibly armed. Despite this, he was not approached, separated from the wing or searched. He was being monitored via CCTV but the cameras do not cover cells. During association, prisoners were in cells, with doors open and easy access to each other. If the prisoner was planning to attack someone, it was distinctly possible that he would do so while prisoners were on association. Although the duty governor was concerned that calling him to the office might have aroused suspicions and prompted an immediate attack, the prisoner had noticed he was being watched closely and was suspicious about what was happening.

135. Had a fuller intelligence picture been available, the risk could have been more clearly assessed for a proportionate response. Since 2004 there had been nine security reports on the prisoner relating to weapons (although in at least three of these the prisoner was believed to have been holding weapons in order to harm himself), in addition to his attack on a prisoner at Frankland. Some of the material the prisoner used to tie the man were strips of bedding torn from sheets in the man's friend's cell, but some he had brought with him, torn from a sheet in a cupboard in his own cell. Had his cell been checked when the second strand of information came through, this might have been discovered.

136. Even without further intelligence we consider that more active efforts should have been made to intervene with the prisoner, based on the information available at the time, which indicated a significant risk. It was not an appropriate response to wait until all prisoners were locked into their cells as self-evidently this would have been too late to deal with any threatened attack on another prisoner during association. Deciding to keep a close eye on the prisoner and monitoring him on CCTV shows that some credibility was given

to the intelligence received. Although the prisoner was subject to closer monitoring, events showed that this was an ineffective response as wing staff were powerless to intervene when he attacked the man in a cell. We make the following recommendation:

The Governor should ensure that staff actively intervene when there is credible intelligence which indicates that a prisoner is intending to commit an act of violence.

Securing cell doors

137. Once in the man's friend's cell, the prisoner was able to close the door and lock himself and the man in. In many prisons, when staff unlock prisoners they open the door then relock with the door open. This is referred to as "shooting the bolt". If the bolt is shot, then when the door is pushed to be closed, the bolt hits the door frame and the door will not close. In Full Sutton, however, it was longstanding practice for staff not to shoot the bolts when unlocking prisoners. This meant that when a prisoner was in his cell, he could choose to lock himself in. Similarly, if he wished to leave his cell during association, when other prisoners were on the landing, he could secure his cell himself rather than relying on an officer to lock it. Prisoners could not ensure the door stayed locked as all staff with keys are able to open all cells doors, but other prisoners could not go in.

138. The prisoner used furniture to barricade the door. Across the prison estate, it is not usual for cell furniture to be secured in position. The main exceptions to this are in the high security estate, and in segregation units. Full Sutton is part of the high security estate and beds, which are large, steel structures, are bolted to the floor. Other furniture is not. As well as for practical reasons, such as being able to clean behind them or check behind them in cell searches, the furniture is not substantial like the beds. If they were bolted down, it would not be difficult for a prisoner determined to do so to break the furniture from the bolts.

139. In light of the man's death, management in Full Sutton reconsidered the custom of not shooting the bolt when unlocking cell doors. It was agreed that with immediate effect, staff would shoot the bolt. There is variation in practice between prisons and after a prisoner was killed in a cell at HMP Long Lartin in February 2013, the Deputy Director of Custody for high security prisons instructed that staff in all high security prisons should shoot the bolt after opening cells. However, he recognised that there were some prisons where this would not always be possible because of logistics, staffing and variations in design. We consider that shooting the bolt is likely to be the safer practice in most circumstances, but recognise that there will be a need to take into account local circumstances. We make the following recommendation.

The Deputy Director of Custody for High Security Prisons should ensure that each high security prison operates an agreed and consistent safe practice in relation to unlocking cell doors.

Reaction to the hostage situation

140. The duty governor told the investigator that there was no local contingency plan for managing hostage incidents at Full Sutton and the policies and guidance that were followed were the national policies. In such a situation there are a number of considerations that need to be taken into account. Not all of them are relevant in every situation. In this case for example the area and situation were contained. There was only a single entry point to the cell, so no plans were required to restrict the area or double-up on teams at different exits. It was necessary to assess the actual threat, while considering whether there might be collusion between the prisoners. Negotiators needed to be identified and brought to the scene, as did control and restraint teams. Information needed to be gathered about those involved. Guidance for hostage incidents is contained in PSO 1400. The PSO says:

> "Governors must consider preparing written contingency plans to assist in the management of negotiable incidents (eg hostage …). Procedures must be reviewed and tested every year to ensure that they meet the needs of the establishment … There must be a clear auditable system that demonstrates that the "guidance for staff" … have been read by all staff at least once a year."

141. Full Sutton did not have local policies in place. It is important that these exist to complement national policies, and that staff are aware of them.

142. Officers were approaching the cell when the prisoner closed the door, and the man's friend indicated to staff that there was a problem. Staff were therefore immediately at the cell door and instantly established that there was a hostage situation. At that point, staff were permanently at the door and in ongoing dialogue with the prisoner. Nursing staff were on the wing by 6.56pm. Trained negotiators were summoned and took over dialogue with the prisoner at approximately 7.10pm. A control and restraint team were on the wing by 7.17pm. The duty governor told the investigator that on his way to the Command Suite he met one of the negotiating team, which helped speed up the process. It took half an hour for negotiators to take over at the cell door. Taking into account the need for briefing this might have been reasonable, but we are concerned that there was no local contingency plan to ensure the smoothest possible process. We make the following recommendation.

The Governor should ensure that there are well practiced local contingency plans for hostage incidents.

143. Cell doors open inwards. To allow staff access in an emergency or barricade situation. The doors have metal plates on the outside so that, if necessary,

they can be removed by loosening three screws. This allows the doors, when unlocked, to open outwards. These plates are called strike bars

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144. Once the cell door had been closed and barricaded, staff managing the situation needed to consider carefully whether they should force entry to the cell. The initial attempts to open negotiation were a reasonable reaction, but during this time the prisoner had tied up the man. Once this had happened he was not able to defend himself. If staff attempted to enter the cell, either by forcing the door inwards or by removing the metal plates and opening the door outwards, the time delay would have been long enough for the prisoner to have harmed the man. The prisoner had barricaded the door, and the view into the cell was obscured for much of the time that staff were negotiating. The prisoner had threatened to harm the man as well as himself and anyone else who came into the cell if staff attempted to come in. We therefore consider the decision not to enter the cell was a reasonable one taking into account the information available at the time.

145. The ambulance service was alerted to the situation, and a rapid-response paramedic and an ambulance attended the prison, arriving at 7.16pm and 7.22pm respectively. The prison gate is put into lockdown during a major incident, so they were held outside the gate and not brought into the prison until the prisoner said he was willing to surrender. There was a period of over half an hour when paramedics were outside. We recognise that the ambulance was allowed into the prison shortly after the prisoner surrendered and paramedics were at the scene quickly. In this case it was too late to save the man, but we consider it would have been prudent to allow the ambulance in so that if paramedics had been required at any time after they arrived at the gate they would have been available without any further delay.

146. A letter from the Department of Health and the National Offender Management Service to Prison Service Governors, NHS Primary Care Trust Offender Health Leads and Prison Healthcare Managers, dated 17 February 2011 about emergency access for ambulance services noted that local protocols should have a “mechanism for avoiding any unnecessary delay in escorting ambulance staff to the patient”. While we understand the security aspect of a lockdown during a major incident, we do not consider that this should lead to any delay with paramedics reaching the scene of an emergency incident. We make the following recommendation.

The Governor should ensure that emergency procedures allow ambulance staff prompt access to prisoners.

Medical response when staff accessed the cell

147. Once staff got into the cell, the control and restraint team were able to see that the man posed no threat. They therefore immediately called for medical assistance and began to untie him. Nurses were in the cell within a minute, and attempts to resuscitate the man began immediately. They began cardiopulmonary resuscitation, while the man was still on the bed. Best practice is to carry this out on a hard surface, but the nurse was satisfied that

the bed provided a firm enough surface to work on. As there were a number of staff in a small cell, moving the man onto the floor would have caused a further delay and made attempts to resuscitate him more difficult. Two minutes after healthcare staff entered the cell, paramedics arrived and joined in the resuscitation attempt. The clinical reviewer comments that resuscitation was initiated and continued in very traumatic circumstances. We are satisfied that the attempts to revive the man once entry had been gained to the cell were swift and as efficient as possible in the circumstances.

Contact with the man's family

148. Guidance recommends that if possible news of a death in custody should be broken to next of kin in person. This was especially important in this case because of the nature of the man's death. As the man's mother lived in London, it would have been an unreasonable delay for Full Sutton staff to have travelled to her home. We are satisfied that it was an appropriate decision to contact a prison nearer to her home so that the message could be delivered in person by a member of the Prison Service. The next day the appointed family liaison officer from Full Sutton contacted the man's mother and offered full support.

RECOMMENDATIONS

For the Deputy Director of Custody for High Security Prisons

1. The Deputy Director of Custody for High Security Prisons should ensure that whenever prisoners are transferred between high security prisons after alleged or proven acts of serious violence the sending prison provides a full account of events, the potential risks and any advice on how best the prisoner should be managed.

2. The Deputy Director of Custody for High Security Prisons should ensure that all known information is taken into account when assessing prisoners' risk, including offences committed in prisons, and that this information is communicated to wing staff to inform their management.

3. The Deputy Director of Custody for High Security Prisons should ensure that vulnerable prisoner status is reviewed periodically and reassessed in light of significant events which indicate the prisoner is a particular risk to other vulnerable prisoners.

4. The Deputy Director of Custody for High Security Prisons should develop a clear strategy to manage prisoners in vulnerable prisoner units who themselves are a risk to other vulnerable prisoners.

5. The Deputy Director of Custody for High Security Prisons should ensure that each high security prison operates an agreed and consistent safe practice in relation to unlocking cell doors.

For the Governor

6. The Governor should ensure that staff actively intervene when there is credible intelligence which indicates that a prisoner is intending to commit an act of violence.

7. The Governor should ensure that there are well practiced local contingency plans for hostage incidents.

8. The Governor should ensure that emergency procedures allow ambulance staff prompt access to prisoners.

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)

1	The **Deputy Director of Custody for High Security Prisons** should ensure that whenever prisoners are transferred between high security prisons after alleged or proven acts of serious violence the sending prison provides a full account of events, the potential risks and any advice on how best the prisoner should be managed.	**Accepted**	A pre transfer proforma has been implemented for use in the high security estate to ensure that the transfer of important information takes place prior to the transfer of a prisoner, for whatever reason (sentence plan progression, CSC, MCBS, compassionate or operational reasons, or segregation. The form allows establishments to include information on the reasons for the transfer and the management strategy to be used for the individual.
			
			In addition to this the High Security Estate is undertaking a piece of work to review the overarching population management strategy, this includes the development of Operating Procedures that will:
			
			• provide clear guidelines for the management of prisoners located within the high security estate who fall under any of the following specific management arrangements:
			    o Category A prisoners
			    o TACT prisoners
			    o High Profile prisoners
			    o Vulnerable Prisoner/Own Protection
			    o Young people
			    o Female Restricted Status prisoners
			
			• provide clear guidelines for the management and decision making in respect of prisoners who present
				September 2013	

			operational challenges either due to: o committing or orchestrating a serious incident within custody, o the nature of their index offence, o their relationships and/or attitudes towards others indicating an actual or perceived risk of harm to themselves or others, or, o Persistent or escalating challenging or problematic behaviour within prison. • provide clear guidelines for the management of prisoners within the HSE who do not fall under any of the strategies above but where additional guidelines support the management of prisoners within establishments; for example, long term segregation, refusal to locate to normal location, prisoners whose behaviour is considered to undermine the Good Order or Discipline of an establishment, either directly or indirectly. • demonstrate pathways for escalation and de-escalation between management strategies • set out the communication, information sharing and transfer arrangements, both within and between establishments to improve the timing, quality and consistency of the sharing of information and transfer of prisoners between those involved in the prisoner's management; to foster a more collaborative and multi-disciplinary approach to ensure the safety of both staff		

			and prisoners in order to achieve a suitable management arrangement for the individuals concerned.		
2	The **Deputy Director of Custody for High Security Prisons** should ensure that all known information is taken into account when assessing prisoners' risk, including offences committed in prisons, and that this information is communicated to wing staff to inform their management.	**Accepted**	The then Director of High Security published an instruction to high security prisons in October 2012 regarding the principles to be applied when assessing and managing risk. These are that: • A recognition that whilst all High Security prisoners are potentially dangerous, the risks they present of serious harm to others do vary between prisoners and over time; and we must take reasonable steps to manage that risk. • A recognition that such risk is dynamic, and that a formal risk assessment must be carried out following significant events and/or receipt of important new information which indicates a heightened risk of serious harm to others e.g. a serious assault; intelligence suggesting an intention to commit a serious assault or worse. • Following such assessment, a risk management plan must be drawn-up to record the actions decided upon; this will usually note which responses or interventions will be deployed e.g. prisoner challenged and advised; IEP review or warning; anti-bullying or other action under the violence reduction strategy; relocation within the prison or to another prison; MCBS/CSC referral. • Ensuring the assessment and actions are	**Instruction published. Ongoing monitoring of compliance will continue**	

			properly recorded and communicated to relevant parties e.g. P-NOMIS updated; CSRA update if applicable; SIR submitted; review through Inter-Departmental Risk Management Team meeting / Security Committee / other forum. In particular, ensuring there is effective handover of information if the prisoner is relocated within the establishment or transferred to another establishment. This is being monitored via the Strategic Operational Managers Meeting (SOMM).		
3	The **Deputy Director of Custody for High Security Prisons** should ensure that vulnerable prisoner status is reviewed periodically and reassessed in light of significant events which indicate the prisoner is a particular risk to other vulnerable prisoners.	**Accepted**	An immediate piece of work was undertaken to develop a protocol for the management of this group of prisoners. The protocol includes the following instructions: Prisoners whose index offence ordinarily would not be deemed as R45 (O/P) compliant are often referred to as a 'Situational Vulnerable Prisoner'. These individuals must be reviewed at least annually at their sentence plan board to ensure that there is no intelligence and/or changes of circumstance which would deem their risk as too great for VP location. They should also be reviewed if they are involved with any type of incident. This review must be endorsed on the CSRA. In addition it provides guidelines for the annual vulnerable prisoner review process: • There will be an annual review of the location of each situational prisoner located	**Complete**	

			on the establishment's VP wings – unless an incident indicates this sooner. • This review will be managed by the Offender Management function using existing tracking tools and databases. • The information will run alongside the sentence planning process and the initial review conducted by the Offender Supervisor (OS) post-sentence plan board once all the risk assessment tools (OASys etc) have been completed. • The Offender Supervisor will use the "Review of Prisoners on VP Location" form (page 14 &15). • Should the review indicate there are concerns about the location of the prisoner being assessed, then the Offender Supervisor will refer the prisoner for a full review by the residential wing management using the "Review of Prisoners on VP Location" form. • Electronic copies of the form will be kept on the OMU databases and a paper copy will be filed in the core record, probation and psychology files; an entry made on ViSOR if a ViSOR nominal, and Security and Intel informed.		
4	The **Deputy Director of Custody for High Security Prisons** should develop a clear strategy to manage prisoners in vulnerable prisoner units who themselves are a risk to other vulnerable prisoners.	**Accepted**	Following the most recent murder in a high security prison an immediate review of all vulnerable prisoners was undertaken to ensure that those who are at risk from other vulnerable prisoners (and vice versa) were kept safe. A new process has now also been implemented whereby prisoners moving from one location to another (and especially those who are	**Complete**	

			vulnerable and/or own protection) will be risk assessed on every occasion. Documented evidence and information will be provided by the sending wing / prison.		
5	The **Deputy Director of Custody for High Security Prisons** should ensure that each high security prison operates an agreed and consistent safe practice in relation to unlocking cell doors.	**Accepted**	An immediate response to this was undertaken. All high security prisons have undertaken risk assessments prior to making the decision on safe practices in relation to unlocking cell doors. This work is ongoing and will be monitored via the Strategic Operational Meeting.	**Complete – to be monitored by SOMM**	
6	The **Governor** should ensure that staff actively intervenes when there is credible intelligence which indicates that a prisoner is intending to commit an act of violence.	**Accept**	Intelligence is assessed and graded under the security 5x5 system. Should there be an imminent risk this is brought to the attention of the duty governor.		
7	The **Governor** should ensure that there are well practiced local contingency plans for hostage incidents.	**Accept**	Contingency plans are in place and this information was provided to the investigator at the time of the investigation and was referred to in the interview which the PPO Investigator conducted with the Duty Governor. A review of contingency plans in line with security and audit baselines is undertaken annually as well as a live hostage contingency exercise inclusive of intervention.		
8	The **Governor** should ensure that emergency procedures allow ambulance staff prompt access to prisoners.	**Accept**	Procedures have been reviewed and contingencies amended.		