PRISONS AND PROBATION OMBUDSMAN for England and Wales

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Learning lessons bulletin

Fatal incident investigations issue 5

Prison Homicides

This Learning Lessons Bulletin examines the lessons to be learned from the mercifully infrequent but nonetheless tragic killing of one prisoner by another in custody.

Since 2003, there have been 16 cases of homicide in prison in England and Wales[1]. In the same period, my office has investigated over 1500 other deaths. While uncommon, the killing of those in the care of the state is a particularly shocking and serious matter. For families, the loss can be impossible to understand and come to terms with. At the same time, these are some of the hardest deaths to learn lessons from. They occurred in 15 different establishments; prisons contain many people who pose a serious risk of harm to others, but very few kill in custody; and learning can be slow to emerge because of the need to build, and then not prejudice, a criminal case against those responsible.

Only once the criminal process has finished can my office complete an investigation. Unlike a criminal investigation, my remit is to examine the circumstances surrounding the death and establish whether anything can be done to help prevent similar tragedies in the future. There is also the opportunity for the families of victims to have their concerns taken into account.

In this bulletin, learning for the Prison Service focuses on the need to have access to - and make use of - all available information when assessing the risk involved in a prisoner sharing a cell, the need to manage carefully the risks that vulnerable prisoners pose to one another, and the need for safe and consistent cell self-locking procedures when this is available to prisoners. Learning these lessons could make homicides in prison rarer still.

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Background on homicides in custody

The victims were broadly representative of the prison population. All 16 were male, the average age was 39 and ten were white. They were serving sentences ranging from life down to a few months, including men held on remand. This bulletin was prompted after a number of common and concerning themes emerged from three homicide investigations which concluded in May and June 2013. Two further homicides occurred in early 2013 but are not included in this report as the deaths remain under investigation.

[1] Until the end of March 2013. The PPO has also investigated the circumstances surrounding two murders in the community; one of an Approved Premises resident, and one of a female prisoner who absconded whilst released from prison on temporary licence. Neither case is considered here.

Cell sharing risk assessments

It is striking, but perhaps not wholly surprising, that half the prisoners died while they were locked in their cell with their cellmate. With a population of over 80,000 and limited space, it is inevitable that most prisoners will share cells. This should only happen after a Cell Sharing Risk Assessment (CSRA) has been completed for both parties. The relevant Prison Service Instruction (PSI 09/2011) says that the 'CSRA is an essential tool in the identification of prisoners at risk of seriously assaulting or killing a cell mate in a locked cell.'

Where prisoners have a history of violence in custody or racially motivated offending, they can pose a risk to other prisoners. This risk is assessed and recorded on a CSRA form. It is Prison Service policy that, with the exception of open prisons, a cell sharing risk assessment should be completed each time a prisoner arrives at first reception or whenever it is proposed to locate the prisoner with another prisoner in a locked cell or other unsupervised enclosed space. This should be reviewed when new or additional information becomes available, or where there is a change in behaviour or other information which indicates they may become more dangerous. A cell sharing risk assessment is required for all prisoners, even those in single cells, because the risk is applicable to all shared spaces. In several of the more recent cases of homicide, victims had single cells in the high security estate and were killed by other prisoners on the wing.

A prisoner can be assessed as high or standard risk. Prior to April 2011 there were three risk levels: low, medium and high risk. A high level of risk does not preclude sharing a cell, but it does require that sharing is subject to careful consideration, risk assessment and, where appropriate, increased supervision. Cell sharing in such circumstances might be necessary due to space shortages, or could be deemed important in other ways such as to provide support for someone regarded as at risk of suicide or self-harm.

The earliest homicide the Ombudsman was asked to investigate occurred in September 2003. Both the killer and the victim had entered the prison within months of cell sharing risk assessments becoming a mandatory requirement. Only the perpetrator had a cell sharing risk assessment, despite the victim sharing with different people and moving between numerous cells in a relatively short period. Since that time, the assessment procedures have been strengthened. However, like all such guidance, it is only as good as its application. Each cell sharing risk assessment requires careful consideration of all the relevant information. The lack of access to, or importance placed on, relevant information is something the Ombudsman has highlighted in a number of these cases.

Case study 1

A high security prisoner, Mr A, seriously assaulted a high profile prisoner on his wing. As a consequence, Mr A was moved to a different high security prison. His cell sharing risk assessment at the receiving prison made reference to a history of violence but not specifically to the recent assault. Staff in the receiving prison told the Ombudsman's investigator that they were unaware of the assault, despite it being widely reported by the media at the time. The staff completing the risk assessment relied on what Mr A told them, rather than consulting his records, which in any event did not adequately document his risk to other prisoners. Even after Mr A was charged with attempted murder for the assault, his cell sharing risk assessment indicated that his risk was low.

High security prisons contain many violent and dangerous men, but it is concerning that such a history of violence against another prisoner was not better recorded, clearly communicated to the receiving prison, or considered more significant when assessing risk. Mr A went on to take a prisoner on his wing hostage and killed him by tying a ligature around his neck. He was found guilty of manslaughter on grounds of diminished responsibility.

All relevant information

A common and related theme was that prison staff did not always have access to, or fully consider, relevant information. Prison records are held electronically on a system shared across the estate, yet some prisoners had arrived at establishments without crucial information about their previous behaviour in prison. Information about risk can be recorded in various ways, including sentence planning, security reports and CSRA forms, but it was not always consistent. Wing staff were not always aware of all the information held about the risk posed by particular prisoners.

Case study 2

A prisoner was locked in a cell by Mr B and Mr C, who then killed and mutilated him before alerting staff to their crime. All three were located on a Vulnerable Prisoner (VP) wing in a high security prison. The victim was convicted of sexual offences against children. Mr B had been in a secure hospital before transferring to the VP wing. Mr C had murdered two elderly women, with a suspected sexual element, so he was also located as a vulnerable prisoner. In both cases, there was evidence that the men posed a risk to other vulnerable prisoners.

Mr B was in prison for trying to murder another patient at a psychiatric hospital. His security file contained several reports that he had threatened violence and had fantasies of killing other prisoners. His cell sharing risk assessments at the prison were very inconsistent; some identified him as high risk, mentioning the nature of his offence, but others assessed him as a low and medium risk.

Mr C made repeated threats to kill staff and prisoners, including threats against paedophiles in particular. Security information recorded this, and the wing manager was made aware. However, this was not recorded in the wing observation book, nor when he moved between wings. A doctor conducting Mr C's mental health review was unaware of graphic plans and fantasies of violence discovered in the diary he was keeping for his mental health nurse. His cell sharing risk assessment was always high, but there is little evidence that his repeated threats led to a review of how to manage his risk or consideration of whether his location as a VP – and proximity to child sex offenders in particular – was still appropriate.

It is important that staff are fully aware of risk and security information about prisoners on their wing. A history of custodial violence needs to be widely known by staff and there should be a clear strategy to manage this risk. The information must be clearly recorded and shared when the prisoner moves between wings or transfers to a new establishment. If the information is not immediately available, establishments should ensure that it is requested and reviewed promptly.

Vulnerability

In both the previous case studies, the victims and perpetrators were housed on vulnerable prisoner wings in high security prisons. VP wings are used as a safe area for prisoners whose offences might make them the target of victimisation or attacks from the general prisoner population and other prisoners who may find it difficult to cope on the main wings. In the most recent cases, it appears that the victim was targeted because they had been convicted of sex offences. Mr A had been moved to a vulnerable prisoner wing because staff were concerned he was not coping among the general population, and he had self-harmed on a number of occasions. He had assaulted a sex offender on a VP wing at his previous establishment, yet the safety of his continued location with sex offenders was not reviewed and he went on to kill a prisoner convicted of sex offences.

In a third case, the victim had requested not to be on the wing set aside for sex offenders and was instead located on a standard wing. His disclosure of sexual offences during group therapy caused significant animosity among other group members, something that was raised with him by staff. However this did not lead to a change in how his risk was managed, nor an assessment of the appropriateness of his continued location on a wing with the other members of the therapy group.

These investigations highlight the need to be aware of potential conflicts between individuals with different vulnerabilities and to manage appropriately prisoners who might need to be held separately from the general prisoner population but are also a significant risk to other vulnerable prisoners. A VP wing was not necessarily an inappropriate location. Given the stigma attached to being a VP, it can be risky to return prisoners to the general population. However, the risk these men posed to others known to be vulnerable was not always widely recognised or proactively managed. Accordingly, two of the most recently completed investigations led to a national recommendation that 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.

Cell doors

Three of the homicides, including two of the most recently investigated cases, occurred when the victim was trapped in a cell by other prisoners. The killer or killers pushed the cell door closed, which locked it behind them. The investigations found that there was a lack of consistency and guidance about 'shooting the bolt'. This is the practice of ensuring that the bolt mechanism protrudes in a locked position which prevents the door from being fully closed. In these three cases, the bolt was not shot, meaning that when the killer pushed the door shut it locked and the victim was unable to leave the cell.

Shooting the bolt has advantages in terms of prisoner safety. Prison staff routinely shoot the bolt when going into a cell with a prisoner, to prevent being locked in and taken hostage.

However, shooting the bolt can also place prisoners and their property at risk. If individuals are unable to close cell doors, they cannot remove themselves from dangerous situations on the wing. More routinely, if the bolt is shot and the prisoner needs to leave their cell unattended, they must wait until a member of staff is available to retract the bolt and lock the door behind them, to protect their possessions while they are away. This is resource-intensive, but the Ombudsman has been obliged to uphold certain complaints when prisoners have been unable to protect their property in these circumstances. It is also possible for other prisoners to gain access and 'plant' forbidden articles, or for the occupant to later claim that this was the case.

Following one of the recently investigated cases, the Deputy Director of Custody for the High Security Estate issued guidance that the bolt should be shot[2]. Other establishments need to consider which approach best promotes prisoner safety in their environment, clearly state their approach in a local policy document and consistently implement this decision throughout the prison.

[2] Two high security prisons were exempted from this guidance.

Lessons to be learned

Lesson 1 – CSRAs should be referenced each time a prisoner changes cell or establishment, and reviewed in light of any new risk information. In particular, prison staff should record any history of custodial violence on the assessment.

Staff need to access the prisoner's records when completing a CSRA, it is not appropriate to rely solely on information given by the prisoner.

Lesson 2 – All information about a prisoner's risk of violence should be highlighted to staff on the wing and this should inform a clear strategy to manage the risk.

Measures to manage those who pose a heightened risk must be robust, widely known on the wing, and shared with others – such as mental health workers – who work closely with the prisoner.

Lesson 3 – Deputy Directors of Custody, particularly for the High Security Prisons, should develop a clear strategy to manage prisoners in vulnerable prisoner units who themselves are a risk to other vulnerable prisoners.

Staff need to be aware of the possible risks posed by vulnerable prisoners to other vulnerable prisoners and keep their location and management under review.

Lesson 4 – Prisons should have a clear local policy on shooting the bolt which is implemented consistently throughout the establishment.

In the absence of national guidance, prisons should consider which approach is safest in their particular environment and ensure consistent practice under their local policy.

The Prisons and Probation Ombudsman investigates complaints from prisoners, those on probation and those held in immigration removal centres. The Ombudsman also investigates all deaths that occur among prisoners, immigration detainees and the residents of probation approved premises. These bulletins aim to encourage a greater focus on learning lessons from collective analysis of our investigations, in order to contribute to improvements in the services we investigate, potentially helping to prevent avoidable deaths and encouraging the resolution of issues that might otherwise lead to future complaints.

The Prisons and Probation Ombudsman's vision is:

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

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