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Learning lessons bulletin

Fatal incidents investigations | Issue 12

Homicides - further lessons

This learning lessons bulletin examines the lessons to be learned from the Ombudsman's investigations into the killing of one prisoner by another. This is the second bulletin we have published on this topic.

Homicides are, mercifully, still rare in English and Welsh prisons, although they have increased over recent years. Yet the killing of one prisoner by another in a supposedly secure prison environment is particularly shocking, and it is essential to seek out any lessons that might prevent these chilling occurrences in future.

In December 2013, I published a previous learning lessons bulletin into prison homicides. The bulletin identified a number of concerns, in particular the need to improve the management of the risk that vulnerable prisoners pose to one another. This led to appropriate operational changes in high security prisons.

Unfortunately, 2015-16 saw another spike in prison homicides with six prisoners killed by another prisoner or prisoners. This was the highest annual number of prison homicides since my office began investigating deaths in custody in 2004. As a result, the then Prisons Minister asked me to look again at the issue and offer a fresh independent analysis of the eight homicide investigations completed since the bulletin in 2013 to see if there was any new learning (at the time of writing there were seven further cases which were still under investigation, as they had to await the outcome of the criminal process).

In short, the cases we studied had little in common beyond their tragic outcome. In five of the eight cases, we also concluded that it would have been difficult for prison staff to have predicted or prevented the death. Nevertheless, what is clear is that the increased number of homicides is emblematic of the wholly unacceptable level of violence in our prisons.

However, the bulletin does identify a number of areas of learning: the need to better manage violence and debt in prison, not least that associated with the current epidemic of new psychoactive substances; the need for rigorous cell searching to minimise the availability of weapons; the need for careful management of prisoners known to be at risk from others; and the need to ensure prisons know how to respond when they have an apparent homicide.

I very much hope the learning from this bulletin contributes to a much needed improvement in safety in prison.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Background

In 2013, the Prisons and Probation Ombudsman (PPO) published a bulletin which considered the lessons to be learned from investigations into homicides in prison[1]. This bulletin looked at 16 homicides investigated in the 10 year period from 2003-4 to 2012-13 (an average of 1.6 per year). In the three years that followed, from 2013-14 to 2015-16, another 13 prisoners were killed by another prisoner or prisoners (an average of 4.3 homicides per year).

As was the case with the 16 victims from the first bulletin, all 13 of the prisoners killed between April 2013 and March 2016 were male. The majority were white (11 of 13), and two were mixed race. The deceased shared few other common characteristics. The average age was 45, ranging from 22 to 80. Sentence lengths varied considerably, as did offence.

The aim of the PPO's fatal incident investigations is to examine the circumstances surrounding the death and to establish whether anything could be done to help prevent a similar tragedy in future. The PPO investigation of a homicide is not a criminal investigation and can only take place once the criminal process has been completed. This inevitably delays our search for any learning.

At the time of writing, PPO investigations into seven of the thirteen prison homicides since April 2013 were still ongoing, or had been suspended pending the culmination of the criminal investigation. This bulletin therefore considered the learning from the six homicides from this period where the investigation had been completed. In addition, it considered two homicides from the beginning of 2013, which were included in the statistics of our previous bulletin, but which were not considered in depth, as the investigations had not been completed at that time.

Could the homicide have been predicted or prevented?

This bulletin was designed to distil learning from our investigations, which could help prevent future homicides. However, the circumstances of the eight deaths were, for the most part, very different and no evident themes were common to all eight fatalities.

The deaths all occurred at different establishments, from local to medium and high security prisons. In some cases, the perpetrator acted alone, in others there were two perpetrators. Some involved weapons, others strangulation or, in two cases, a punch. In some cases, the victim and perpetrator were cellmates, or knew one another well, in others there was little evidence of previous contact between the victim and his killer. There was also variation in the outcome of the criminal proceedings. In four of the eight cases, one or more prisoners were convicted of murder, three cases led to manslaughter convictions, and in one case the prisoners concerned were acquitted.

As part of each of our fatal incident investigations, we consider whether there was anything that could reasonably have been done to prevent the death. In one case in our sample, we found that too little consideration was given to events that might have made the victim vulnerable to attack. In two other cases, we found that it would have been difficult for the prison to have identified that the victim was at particular risk from their attacker, but there were concerns over the lack of a structured and co-ordinated approach to challenging violent behaviour.

In the remaining five investigations, we concluded that it would have been difficult for prison staff to have predicted or prevented the death, even though areas for improvement were still identified in some cases.

Tackling violence

The increase in prison homicides comes against a backdrop of a troubling rise in the level of violence and disorder reported in our prisons. There was a 27% increase in assaults and a 31% increase in serious assault incidents in prisons in 2015, compared with the previous year[2]. The use of new psychoactive substances (NPS) in prisons is also an increasing concern (and was the subject of a previous learning lessons bulletin[3], which identified examples of NPS users acting violently and out of character, or getting into drug debts, resulting in bullying, intimidation and violence).

With increased violence comes an inherent risk of more fatalities. In two of the eight deaths reviewed for this bulletin, the death occurred as a result of a punch to the head. There was no evidence that the assailants intended to cause the death of their victims and both were convicted of manslaughter, not murder. However, the incidents reflected the wider problem of violence in those prisons. In both of these prisons, recent inspections by HM Inspectorate of Prisons had found high levels of violence and inadequate systems for addressing and managing violent incidents. One prison was also found to have a serious problem with NPS and related debts and violence.

Case study A

During his time in prison, Mr A had a poor disciplinary record. He had been involved in a number of assaults, and illicit substances had been found in his cell, including new psychoactive substances (NPS) and mobile phones. Staff and prisoners we spoke to as part of our investigation said that Mr A was in debt for drugs, mainly NPS, and that he was easily influenced and vulnerable. We were told that he held items, such as drugs or mobile telephones, for other prisoners. He also delivered drugs for other prisoners, and cleaned prisoners' cells to help repay his debts.

Three months before his death, Mr A was transferred to another prison. Initially, he settled well but, two weeks later, staff found a phone charger in his cell. He said he was holding it because another prisoner had threatened him into doing so. He was moved to another wing, but there is no record of an investigation into the claims that he was being threatened.

Mr A began to miss work and was charged with a disciplinary offence. He was moved to the segregation unit as punishment. He began self-harming and said that prisoners he worked with were threatening him. He identified the prisoners who he said were bullying him, but there was no record that an investigation took place. Mr A was moved back to a normal wing.

One morning the following month, there were three incidents in quick succession where a prisoner was assaulted, threatened, or chased by other prisoners. Mr A was involved in at least one of these incidents. Later that morning, Mr A went into another cell where there were two other prisoners inside. Shortly afterwards, one of them pushed Mr A out of the cell. A third prisoner was standing outside the door, who then punched Mr A in the jaw and he fell to the floor.

When officers arrived, Mr A was still lying on the floor. He was awake but disoriented and there was blood on the back of his head. He was taken to hospital, where he was diagnosed with bleeding on the brain and a cracked skull, and was placed in an induced coma. A week later Mr A died in the hospital after he contracted a chest infection and had a cardiac arrest.

We considered that the prison had little reason to have predicted this incident, or to have kept Mr A and his assailant apart. There was no intelligence to link the two prisoners, and staff considered that the assailant was not normally aggressive and that his actions were out of character. However, our investigation found that the easy availability of NPS at the prison had led to increased levels of bullying and violence, and a general lack of safety. We were particularly concerned that the prison did not appear to be dealing with these issues effectively.

Mr A was apparently in debt to other prisoners due to his use of NPS. Drug related debts can make prisoners vulnerable to bullying, intimidation and violence. Mr A told staff on two occasions that he was being bullied or threatened, but we found no evidence that these allegations were investigated. In these circumstances, the occurrence of serious assault is not wholly surprising, and Mr A's vulnerability should have been recognised and addressed.

If prisons are to prevent homicides, bullying and violence - including that associated with NPS - need to be tackled in a robust and coordinated manner. Any allegations of such activity should be taken seriously and investigated appropriately. Suspected perpetrators should be monitored and challenged through effective interventions, and potential victims should be supported appropriately.

Weapons and cell searching

Along with the increase in assaults in prison, there has been a notable increase in the number of assaults involving weapons. There were almost 4,000 assaults involving the use of weapons in prisons in England and Wales in 2015, a 38% increase on 2014. Almost one in five assaults in 2015 involved the use of weapons, compared with one in ten only five years previously[4].

Although the unauthorised possession of a knife or another offensive weapon in prison is a criminal offence, the availability of weapons is a serious concern. In two of the eight cases reviewed, an improvised bladed weapon was used in the fatal assault. Tackling the possession of weapons should be an integral part of a prison's violence reduction strategy, and conducting rigorous cell searches can be an effective way of identifying and removing weapons.

Case study B

Mr B had spent eight years in prison. During his time in custody, he was violent towards others, including prison staff. He also had a history of substance misuse and self-harm. In his final months in prison, Mr B was moved to a specialist unit at the prison which had been developed as part of the national offender personality disorder strategy. It was designed to manage violent and high-risk prisoners with emotional and behavioural difficulties, to address their behaviour and help them to progress with their sentence plans, in preparation for life in the community.

Mr B appeared to settle well in the unit. He attended engagement groups and interacted well with other prisoners. One morning, he took part in a group therapy session. At the meeting, the topic of sex offenders and abuse was discussed. During this discussion Mr B got up and left the meeting. At this point, another prisoner told the group that Mr B had looked at him as if he had accused him of being a sex offender. After a short time, Mr B returned to the meeting and apologised, telling the group that the topic had triggered memories and upset him.

Later that evening, two prisoners asked to speak privately with an officer. Both prisoners had attended the group therapy session with Mr B that morning. One was the prisoner who said he thought Mr B looked at him accusingly, as if suggesting he was a sex offender. The two prisoners told the officer that there was a dead body in one of their cells. The officer accompanied the prisoners to the cell, where he found Mr B's body. Mr B was lying face down on the bed with blood around his head and body. When paramedics arrived they confirmed that he was dead.

The post-mortem examination found that Mr B had 190 puncture wounds to his body and had died from multiple stab wounds to the chest. The two prisoners who alerted the officer were charged with his murder. One of them told officers where they had hidden the weapons they used to kill Mr B. Staff later recovered two homemade bladed weapons.

Mr B, and the two prisoners who were charged with his murder, all had a history of violence in prison. They were all residents of a specialist unit, where they took part in a programme designed for violent, high-risk offenders. Despite the dangerous nature of the prisoners in the unit, our investigation found that there was an inadequate programme of cell searching. Prison Service Instruction (PSI) 68/2011, Cell, Area and Vehicle Searching, sets out a national security framework on searching and says that all parts of the prison must be searched at a level and frequency set out in local security strategies. The PSI says that all prisons must carry out intelligence-led searching, and that prisons not in the high security estate must conduct a local risk assessment to determine whether a programme of routine cell searching is needed.

While the prison where Mr B died was not a high security prison, the unit where he was living housed a concentration of particularly dangerous prisoners. Our clinical reviewer noted that random searching took place in equivalent NHS units, where the profile of patients would be similar to those in the prison's specialist unit. She was surprised that there was no detailed strategy for routine and random searching of the unit.

Our investigator asked the prison for information about how many cell searches, both intelligence-led and routine, had been carried out in the unit and the rest of the prison in the year before Mr B's death. He also asked how many weapons had been found. The PSI says that there must be arrangements for keeping records of searches and finds, but the prison did not have this information.

Intelligence-led, targeted searching can be effective for finding weapons and other illicit items, and can be an efficient use of resources. However, we were concerned that the prison did not have readily available information about any intelligence-led searching that had taken place. The use of routine and random searching would also have been prudent given the high risk nature of the prisoners in the unit, and may have helped to tackle the prevalence of weapons. It is important that searches are carried out in line with the PSI and that searching arrangements fully reflect the risks of the prisoners involved, for the protection of both prisoners and staff.

Risk factors and vulnerability

Our previous bulletin about prison homicides looked in detail at the risks posed to vulnerable prisoners because of the nature of their offence, particularly from other vulnerable prisoners. Some victims appeared to have been targeted due to their history of sexual offending or offences against children, by other vulnerable prisoners with different backgrounds.

In the cases reviewed for this bulletin, we again found instances where it appeared that the motive for the killing was related to the prisoner's status, or perceived status, as a sex offender. We did not find evidence of prisoners known to be a potential risk to sex offenders being co-located in vulnerable prisoner units. However, in one case we were concerned that a prisoner with a history of sexual offending was not located in the vulnerable prisoners unit. It is possible that this was his own choice, but we found no evidence that anyone had discussed with him his preferences, or the potential risks of staying on a standard wing. After he died, other prisoners suggested that the reason he was fatally assaulted was because he was a sex offender.

The nature of a prisoner's offence is only one factor which might make a prisoner vulnerable to attack from others. The case of Mr A indicated that drug use and debts might put a prisoner at risk. There are a number of risk factors which might indicate a prisoner's heightened vulnerability and the need for additional protective measures to be put in place to ensure their safety. When prison staff have information to suggest that a prisoner could be at risk from others, this information should be recorded, the severity of the risk evaluated and any necessary protective measures implemented.

Case study C

When Mr C first arrived in prison, he was involved in a disturbance on the wing. It appeared that he had an altercation with a prisoner who had links with a notorious street gang. Mr C told staff he was concerned about repercussions, and was moved to another spur. About two months later, staff began to make entries in Mr C's prison records about him being reluctant to leave the wing for work because he said he was under threat from other prisoners. However, he refused to name the other prisoners, and an officer speculated that he was claiming to be under threat in order to avoid work.

A few weeks later, Mr C reported that he had been assaulted by three prisoners. He was asked if he wanted to be moved to the vulnerable prisoner unit, but he said no. An officer investigated the assault and another prisoner reported that he understood that it was Mr C's cellmate who had assaulted him. This information was passed to the safer custody team who asked Mr C if this was true. Mr C denied this, and said he was happy to continue sharing a cell with his cellmate. No one spoke to his cellmate about the accusation against him.

An officer from the safer custody team wrote in a violence reduction report that they suspected that Mr C's cellmate might have been responsible for the assault, but that there was no evidence to support this. The officer also wrote that Mr C was worried about his safety and that he would like to move to another prison. The officer recommended trying to arrange a transfer and opening a 'tackling antisocial behaviour' (TAB) document. This is a document used to help manage victims or perpetrators of potential antisocial behaviour and bullying.

Four days later, property went missing from the cell of two prisoners who lived on the same house block as Mr C and his cellmate. One of the prisoners from that cell alerted a prison officer, who began checking cells to see if he could find the missing items. While conducting this search, Mr C's cellmate told the officer that he had the missing items and that he hadn't taken them, but knew who had. The officer took four bags of belongings from Mr C's cellmate, and returned them. However, when the items were returned, the prisoner who reported them missing said the missing property was not all there. He was angry and shouted across the landing to Mr C's cellmate, demanding information about his property.

Shortly afterwards, another prisoner told officers that he believed Mr C's cellmate was bullying Mr C, that he had concealed weapons around the wing, and that he was intending to attack one of the prisoners whose property had gone missing. The same prisoner also told officers that he had heard one of the prisoners whose property had gone missing saying that he would kill the person who had taken it. Mr C's cellmate was moved to the segregation unit pending investigation into the allegations against him. Mr C remained on the wing, but was moved to a different cell so that the cell he had shared could be searched for weapons and any remaining property.

A short while later, an officer heard a shout from the cell from where the property had gone missing. The officer went to the cell and found Mr C semi-conscious and lying on the floor. He had facial injuries and was bleeding heavily. He was taken to hospital, where he died three days later. A post-mortem examination gave his cause of death as raised intracranial pressure secondary to head injury. One of the prisoner's whose property had gone missing was charged with his murder.

Our investigation into the death of Mr C found there were two occasions where he was identified as at risk of harm, but no action was taken to move him to another location. First, when a prisoner reported that he thought Mr C's cellmate was responsible for assaulting him. Mr C denied this, but when a prisoner is being intimidated by a cellmate they will often be unwilling to report this for fear of the consequences. It would therefore have been prudent for Mr C to be moved to a different cell.

The second occasion was after missing items had been found in Mr C's cell. His cellmate was moved to the segregation unit, but Mr C was moved to another cell on the same house block, only three cells away. Officers were aware that the two prisoners whose property had gone missing were very angry, and knew that their property had been in Mr C's cell. Officers had also been told that one of these prisoners had threatened to kill whoever had taken his property. Given these circumstances, staff should have been aware that Mr C was potentially vulnerable to attack. When there is evidence to suggest that a prisoner's safety is at risk, action must be taken to protect that prisoner. Such action might have saved Mr C.

Responding to serious assault or homicide

Homicides are appalling occurrences, and it is essential that prisons take all possible steps to prevent them. However, when they do occur, it is important that prison staff know what steps to take when a prisoner is killed by another prisoner.

At any time when it appears that a serious criminal offence has occurred, prison staff are required to immediately contact the police by the Prison Service Instruction covering prisoner discipline procedures, PSI 47/2011. This includes every apparent incident of serious assault against a staff member or a prisoner. In every incident when a prisoner has been seriously assaulted, whether or not it is suspected at that time that the prisoner may die from their injuries, the police should be contacted straight away.

When a serious incident does occur, PSI 09/2014, Incident Management, makes clear that prisons should have contingency plans in place to ensure incidents are resolved with the minimum of harm to staff, prisoners and the public, and that evidence is preserved. Prison staff should also ensure that they safely secure all other prisoners who they believe might have been involved in the incident. Such prisoners may be suspects or witnesses, and it may be detrimental to the police investigation if they can discuss their version of events with others.

As well as securing any prisoners potentially involved with the incident, it is important that staff also ensure that any physical evidence is not tampered with. Appropriate and prudent action by prison staff in the aftermath of a serious incident can contribute towards the delivery of justice when a criminal offence has occurred. However, when errors are made immediately after a serious incident, it is possible that the police investigation and any prosecution can be compromised.

Case study D

One evening Mr D was standing on a landing in the prison. Another prisoner walked by and punched him on the head. Mr D fell to the ground and the other prisoner walked away. When officers arrived they found Mr D to be unconscious and bleeding from his head. They radioed for medical help and a nurse arrived.

Several prisoners began crowding around the scene. One prisoner told an officer who had hit Mr D, and the officer passed this information onto a senior officer and a manager. The nurse asked that the prisoners crowding round be moved away, and offers began locking prisoners in their cells. The man who punched Mr D was returned to his cell, and locked in with his cellmate.

Another nurse and a healthcare assistant arrived on the scene shortly after. This nurse began to clean up Mr D's blood from the floor, as he considered it to be a hazard. An ambulance was called and, when paramedics arrived, they found that Mr D was in a critical condition. He was taken to hospital.

About 40 minutes after officers first became aware of the incident, the senior officer and manager who had been informed about the man who hit Mr D went to this man's cell. They found him sitting on the bed, while his cellmate was talking on their in-cell phone. At this point, they took him to the segregation unit

When Mr D arrived in hospital, it was found that he had a fractured skull and a bleed on the brain. He was pronounced dead later that evening. Only after Mr D died did the prison call the police. This was more than three hours after the assault occurred.

It is of concern that it took so long for the police to be contacted. When officers found Mr D, it soon became apparent that he had been seriously assaulted by another prisoner. On their arrival, paramedics reported that he was in a critical condition. When this became known, police should have been called immediately.

The delay in taking the assailant to the segregation unit was also of concern. As soon as staff received information about the person responsible for the assault, they should have separated him, until they could learn more about the incident and inform the police. Instead, they at first returned him to his own cell where they locked him in with his cellmate. In this time, important evidence could have been lost. The cleaning up of Mr D's blood was also of concern, as this should have potentially been preserved as evidence, subject to the safe functioning of the prison. The investigation found that the prison had not shared their protocol for preserving evidence with healthcare staff.

In four of the eight homicides considered for this bulletin, we raised concerns over the events that took place immediately after the incident, regarding the preservation of evidence or the separation of prisoners who were involved or witnessed the homicide.

Endnotes

1 Prisons and Probation Ombudsman (2013), Learning lessons bulletin: Prison Homicides. Available online: http://www.ppo.gov.uk/?p=3719

2 Ministry of Justice (2016), Safety in Custody Statistics England and Wales, Deaths in prison custody to March 2016, Assaults and Self-harm to December 2015. Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/519425/safety-in-custody-march-2016.pdf

3 Prisons and Probation Ombudsman (2013), Learning lessons bulletin: New Psychoactive Substances. Available online: http://www.ppo.gov.uk/?p=6137

4 Ministry of Justice (2016), Safety in custody quarterly update to December 2015, Assaults in prison custody 2000 to 2015. Available online: https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2015

Lessons to be learned

Lesson 1
All prisons should have a coordinated approach to identifying indicators and risks of bullying and violent behaviour, including the impact of new psychoactive substances and associated debt. All allegations of violence, bullying, or intimidation should be taken seriously and investigated appropriately. Suspected perpetrators should be monitored and challenged through effective interventions and potential victims supported as part of a robust violence reduction strategy.

Lesson 2
All prisons should have an effective security and searching strategy, which reflects the specific risks of the prisoners housed there, and enables weapons to be found and removed and, where appropriate, their owners charged or disciplined.

Lesson 3
Concerns about the potential vulnerability of prisoners should be properly recorded and considered. When a prisoner is identified as potentially at risk of harm from another prisoner or prisoners, action should be taken to ensure they are appropriately protected and located in a place of safety.

Lesson 4
When a prisoner appears to have been seriously assaulted, the police should be notified without delay. All relevant evidence should be preserved, subject to the safe functioning of the prison, and all prisoners who were potentially involved in the incident, either as suspects or direct witnesses, should be identified quickly and held separately until the police arrive.

The Prisons and Probation Ombudsman investigates complaints from prisoners, young people in secure training centres, those on probation and those held in immigration removal centres. The Ombudsman also investigates deaths that occur in prison, secure training centres, secure children's homes, immigration detention or among 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.

PPO's vision:

To carry out independent investigations to make custody and community supervision safer and fairer.

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