

**Investigation into the circumstances surrounding the  
murder of a prisoner at HMP Full Sutton, who died on 16  
September 2005**

**Report by the Prisons and Probation Ombudsman for  
England and Wales**

**July 2007**

The man who is the subject of this report died on 16 September 2005 at a hospital in Yorkshire. The man was a prisoner at HMP Full Sutton and had been the subject of a vicious attack by two other prisoners who had taken him hostage in his cell twelve days earlier. His arms had been tied up, his head covered with a blanket, and he had been beaten and strangled before falling unconscious.

He remained a hostage for about an hour before medical staff were able to enter the cell and administer assistance. The man was taken to hospital and placed on a life support machine, but did not recover. He was 77 years old and remained in hospital until his death.

This is a report into the circumstances surrounding the killing.

Due to police enquiries and the subsequent criminal trial, it was necessary to suspend my investigation pending the completion of court proceedings. My investigation was reopened once the trial had been concluded with two convictions for murder. As what happened in the man's cell has been fully investigated by police and explored at court, I have dealt in the main with the events leading up to the point where he was taken hostage. I am satisfied that the prison had no prior warning that he was vulnerable to attack by the prisoners, and so could not have prevented it. However, I draw attention to the unsatisfactory state of the prison's command suite, a surprising circumstance in one of the country's high security prisons.

I wish to thank the management and staff of Full Sutton for their support and for making my investigators welcome. I offer particular thanks to the liaison officers and administration staff for their invaluable support.

The loss of any family member is distressing, but especially so whilst they are in custody, vulnerable and die in such horrific circumstances. My investigator and I offer our sincere condolences to the man's family and friends.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

On Sunday 4 September 2005, the prison security department at HMP Full Sutton received a Security Information Report (SIR) to say that a prisoner on F wing was believed to be bullying two other prisoners on the wing. The information had been given to an officer by a prisoner. The SIR named two prisoners who had in turn apparently made it known to other prisoners that they were intending to stab the alleged bully. The SIR was analysed the same day by intelligence staff, and their assessment was that officers on F wing should monitor the situation.

Whilst monitoring the movement of the alleged bully and the two prisoners reported to be planning to carry out the stabbing, F wing officers became aware of another prisoner who had positioned himself in view of one of the wing internal cameras and remained close to prison staff. The reason for his doing this was two fold: to make himself highly visible to prison staff, and to show the other prisoners that he was in full view of prison staff.

At 5:15pm, the two prisoners who had made it known that they were going to stab an alleged bully were seen by prison officers to enter the dead man's cell. This was followed immediately by a loud commotion. Believing that a fight had broken out in the cell, officers raised the alarm and went to the cell to see what was occurring.

An officer unlocked the man's cell door and managed partially to push the door open. However, the door was immediately kicked shut by one of the prisoners. Further attempts to unlock the door failed, as the two men had erected a barricade against the door. Additionally, the door observation window had been covered over thus preventing the officers from seeing into the cell. One of the officers is a trained hostage negotiator, and believed at this point that the man had been taken hostage.

At 5:25pm, an officer spoke to the two prisoners [perpetrators] and asked if he could speak to the man. One of the perpetrators agreed and removed the cover from the cell door observation panel. The officer could see a figure slumped in a chair, tied up and covered with a blanket. When he called out to the man, the officer did not receive a response.

During the hostage negotiations, the duty governor informed the negotiator that the man had a potentially serious illness. The negotiator told the two hostage-takers about the condition. At 5:50pm, following further negotiations, one of the perpetrators passed a home-made knife to the negotiator.

As part of the normal hostage contingency plans, discussions were taking place in the background with the perpetrators. During the lines of communication, arrangements were being discussed with those in charge of the situation on how any eventual surrender plan by the prisoners would operate.

At 6:00pm, a surrender plan was agreed. Fifteen minutes later, the two perpetrators took the barricade down, and the officers waiting outside were able to unlock and open the cell door. Both perpetrators co-operated fully with instructions and were taken to the prison's segregation unit.

A principal officer (PO) was the first person to enter the cell after the two perpetrators had left. He removed the blanket which was still covering the man's head. He spoke to him, but did not obtain a response. He was aware that the man was breathing, albeit with difficulty. He could see his arms were cut and tied behind his back and blood was coming from his left ear.

A prison nurse also entered the cell and, with the assistance of the PO, moved the man onto his bed for further examination. Her tests showed that he was unresponsive but breathing. Two members of the emergency ambulance paramedic team were waiting just inside the prison and able to be at the cell very quickly. Once required, they attended F wing and administered oxygen to the man. Their assessment was that he was breathing but in a critical condition which required an immediate emergency transfer by ambulance to hospital. The man was taken to hospital where he was placed onto a life support machine. Sadly, at 1:07am on 16 September 2005, the man died without ever having regained consciousness.

## THE INVESTIGATION PROCESS

1. On 19 September 2005, one of my assistant ombudsmen, and an investigator, opened the investigation on behalf of the lead investigator, who at the time was on leave. They met the Governor, prison's liaison officer, a member of the Full Sutton Independent Monitoring Board (IMB), and a member of the local branch of the Prison Officers' Association, and briefed them on how the investigation would proceed. After the meetings, they visited F wing and viewed a cell similar to the man's as his own cell remained sealed by the police as it was the scene of a crime.
2. To save unnecessary confusion, notices informing staff and prisoners of my investigation were not displayed. It was felt that they might cause uncertainty as between my work and that of the police. However, in a notice to staff and prisoners, the Governor made everyone aware that my office would be investigating the death in line with my commission to investigate every death in custody.
3. The investigators then examined copies of the record of the events, including post incident Security Information Reports which indicated that one of the perpetrators involved had admitted injuring the man and hoping that he was dead.
4. On 30 September, the lead investigator took over responsibility for the investigation and met the Governor and liaison officer at the prison. He received a briefing from the Governor and visited the area where the man had been taken hostage.
5. On 5 October, the lead investigator and another of my investigators met the police officers investigating the death at their incident room. The meeting had been requested to agree the protocol for how my investigation would proceed alongside the police investigation. The lead investigator sought the advice of one of my deputy ombudsmen, and she agreed that the investigation would be suspended until after the completion of the criminal trial. On 1 November, the investigators returned to the prison to begin cataloguing the documents which the Governor had made available to them. They completed their work on 2 November and closed the file pending the completion of the trial. Having pleaded guilty to the charge of murder, the two perpetrators were sentenced to life imprisonment on 18 December 2006.
6. On 17 October 2005, one of my family liaison officers (FLO), spoke to the man's former wife. The FLO explained that my investigation would not proceed until after the police had concluded their case. (A key purpose of contacting the family is to allow them the opportunity to raise any concerns that my investigation should consider.)
7. On 12 January 2007, my lead investigator received confirmation from a detective superintendent that this office's investigation could be reopened. On 12 February, the lead investigator returned to Full Sutton and met a member of the prison's management, and Security PO, he also met the new Governor.

8. Following confirmation that my investigation could re-open, the FLO contacted the man's former wife once again to ask if she would like to be involved with the investigation process. On 27 March, she received confirmation that the man's former wife would like to be kept involved and to see my report in due course. She told the FLO that she believed the man was waiting for an operation, that he was not well and had lost weight. She asked me to consider whether the healthcare arrangements were adequate, and whether the man was waiting an unreasonable time for an operation. I have done my best in this report to answer these questions.

## THE MAN

9. The man was born in Yorkshire, in 1928, coming from a large family that left Yorkshire soon after his birth.
10. To try and answer the questions raised by his former wife, my FLO wrote to the prison's liaison officer. I am grateful for the information in the following paragraphs which has been supplied by the prison.
11. On 13 July 2005, the man was seen by a doctor and nurse as he had swallowed a piece of plastic which had snapped away from his dentures. The doctor examined the man and found that he was showing signs of excessive weight loss, and asked for an x-ray and blood test to be carried out.
12. Five days later, the man had an x-ray carried out at the prison and the film was sent to an external radiology department. The result, which was relayed to the prison on 20 July, showed signs of abdominal aortic aneurism. On 22 July, the prison doctor discussed the results with a consultant vascular surgeon and he advised that the man should be referred for a routine abdominal ultrasound examination. The examination was carried out on 4 August and reported back to the prison the following day. It confirmed a 4.5 cm diameter aneurism.
13. On 17 August, the consultant wrote to the prison doctor advising that no further action was required at that stage, and suggested a further scan six months later. Six days later, the prison doctor wrote to a consultant gastroenterologist raising his continuing concerns at the man weight loss. He also booked a follow up scan, but the man had died before it took place.

## **HMP FULL SUTTON**

14. HMP Full Sutton opened in 1987 and is a modern, purpose built, maximum-security prison located 11 miles east of York. Its primary function is to hold in conditions of high security some of the most difficult and dangerous men in the country.
15. The prison has seven residential units and a segregation unit and a healthcare centre. E and F wings provide single cell accommodation for up to 48 men per wing. The design allows staff good observation throughout and is further enhanced by CCTV coverage of the internal areas. Due to the level of observation available, E and F wings have been used to accommodate prisoners who have not coped well on other wings, or who have been difficult to manage. Additionally the two wings accommodate those prisoners who, as a result of their notoriety or vulnerability, require greater observation.
16. Each cell has an inundation point, which is a small opening in the door to allow staff to connect a fire hose to a cell. When the water is turned on, the inundation point is designed to spray water into the cell. The inundation system prevents any possible flash back which could otherwise occur if the door of a burning cell were opened.

### *Security Information Reports (SIRs)*

17. Security Information Reports are used by staff to inform the security department of any intelligence they believe important. Although information is regularly passed into the security department, it is not necessarily acted on straightaway. This is dependent upon the nature and source of the intelligence and its reliability. (Security information is often passed to staff anonymously.) However, all the information is analysed and assessed. Once submitted, the SIR is broken down into three further sections and the assessment and decisions are commented on by the security manager and duty governor.

### *Staff Observation Books*

18. Observation books are used by any member of staff to pass on information to other members of staff. Unlike SIRs, observation books are used as a general information document.

### *Incident Command*

19. Every Prison Service establishment has in place a set of contingency plans for dealing with specific incidents. As part of the contingency plans, they all have an area which in the event of a serious incident can be utilised as a command suite. Command suites vary from prison to prison. They can be anything from an office which has another primary function to a dedicated suite used solely for that purpose. Command suites have telephone access, computer facilities and local contingency plans.
20. During any protracted incident, the Prison Service uses a command structure

that identifies various areas of responsibility. There are three levels:

- Gold: The gold commander is based at Prison Service Headquarters in London. Providing the incident is of such a serious nature to require the gold command suite to be opened, the gold commander will take overall charge. The gold commander is assisted by senior police officers and specialist staff trained to deal with specific incidents.
- Silver: Silver commanders are normally a prison governor grade based in the establishment where the incident is taking place. They initially take charge of an incident, but depending on the seriousness of the event will make direct contact with the duty gold commander. Silver commanders liaise directly with the gold commander and also bronze commanders. As with gold command suites, prison command suites require sufficient space to accommodate a number of key advisors and personnel.
- Bronze: There can be a number of bronze commanders involved with any one incident and they can be of any grade. They each have specific tasks to carry out and work directly to the silver commander.

## KEY FINDINGS

21. On Sunday 4 September 2005, prisoners were not required to work and were instead taking association. (Association periods allow prisoners to interact with each other and, should they choose to do so, to meet other prisoners in their cells. Additionally, they can cook food, watch television, play pool or simply relax.)
22. During the morning, information was given to an officer by a prisoner on F wing that two prisoners [perpetrators] were being bullied by another on the same wing. The officer opened an SIR and, after completing his report, passed it to the security department. The alleged bully was described by the informant as a black prisoner. The informant told the officer that he [the alleged bully] was going to be stabbed by the perpetrators. Although a name was not given by the informant, the officer thought that he knew whom the prisoner was referring to and wrote a name on the SIR. The SIR, which was later given a unique reference number by the security department, does not indicate how the officer came to this conclusion.
23. The security assessment shows no previous links between any of the prisoners named, but notes that the information given by the informant was usually good. Staff on F wing were advised to monitor the situation and anti bullying observations were opened on the prisoner identified by the officer
24. Further information from officers on F wing shows that they had noticed another prisoner who appeared to be staying in the vicinity of staff and wing cameras. As this was unusual for the man concerned, it led officers to believe that he may have known of the perpetrators plans and possibly suspected that he was the intended target. A further SIR form was raised to the security department telling them of their suspicions. The SIR shows that the prisoner sitting near to the cameras was neither the dead man nor the one referred to as the alleged bully in the earlier SIR.
25. My investigator examined the wing observation book to identify what instructions had been given to F wing staff following the SIR assessment. Unexpectedly, the observation book does not show any instruction from the security department to monitor the situation, or indicate any possible threat to the alleged bully.
26. However, although there was no reference to monitoring the perpetrators in the observation book, anti bullying observations had commenced. The investigator was given an explanation by the liaison officer on how security information was shared. He was told that, after the daily morning meeting with the Governor and all managers, the manager for F wing was given an action sheet which gave instructions about observing the two prisoners concerned. It was the responsibility of the manager to ensure wing staff were made aware of the security requirements. Although not written into the observation book, I am satisfied that proper observations were in place.
27. There are only two entries in the observation book for 4 September. One was made at 7:40pm, and there is a further entry at 10:00pm. The entries suggest

that the prisoner who had been observed sitting close to wing cameras and prison staff was possibly the intended target.

28. At approximately 4:55pm, the man collected his evening meal from the servery situated on the ground floor of F wing. After collecting his meal he returned to his cell.
29. Approximately 20 minutes later, the perpetrators were seen by officers to enter the man's cell. The officers were suspicious, as it was unusual behaviour for the three to be seen together. Officers heard a commotion coming from the cell and heard the cell door being closed. An officer pressed one of the wing alarm bell buttons to alert the rest of the prison that there was a problem in the wing and that assistance was required.
30. An officer went to the man's cell and after unlocking the door, managed partially to open the door. However, one of the perpetrators jumped at the door with both feet forcing it to close and lock, leaving the man inside along with the two perpetrators. The officer was quickly assisted by other prison staff. At this point, one of the prison's trained hostage negotiators decided that the circumstances were that of a hostage situation.
31. The PO went to F wing to assess the situation for himself. When he arrived he was told that a prisoner was being held hostage by two others. He gave instructions to lock all the remaining prisoners, who at that time were still unlocked, back into their own cells. All prisoners cooperated with the officers and returned to their cells, allowing prison staff to deal with the situation.
32. At the same time, the duty governor went to the prison command suite. His role at this point was to act as Silver Commander and take control of the situation from the command suite. The PO, as the senior uniformed officer on F wing, assumed the role of Bronze Commander which meant that he worked directly to the instructions of the deputy governor.
33. When the duty governor arrived at the command suite, which at the time was also being used as the prison's intelligence office, he found the office empty as the staff had left for the day. He told my investigator that he was faced with a suite with a large number of unrelated intelligence documents covering the desks. He said the prison's contingency plans were not readily available and, after searching for them, he found they had been placed into storage boxes under a desk and on top of a cabinet. Additionally, he was unable to log into the command computers as they were not connected to the electrical main system and the internal batteries did not have sufficient power to operate them. However, as he is an experienced governor, he knew what he was looking for and was able to locate the hostage contingency plans reasonably quickly. Although faced with a chaotic command suite, he quickly contacted Prison Service Headquarters and briefed the on call Gold Commander about what had occurred.
34. The Gold Commander took overall control of the situation which meant that, before any actions were taken at the prison, he would have to give his

authorisation. He gave instructions to open the gold command suite based in Prison Service Headquarters and to implement the hostage contingency plans.

35. In the meantime, the hostage negotiator began talking to a perpetrator through the locked cell door. The negotiator later told police officers dealing with the case that a perpetrator had said to him, "He's a fucking nonce ... he killed those people years ago." The perpetrator also told the negotiator that he had a home made knife in his possession, adding that the man had been assaulted, bound and gagged.
36. Shortly before 5:25pm, the same perpetrator asked to speak to his personal officer. The personal officer spoke to him through the locked cell door. The perpetrators demanded a police negotiator and camera to be at the cell, although the reason for this remains a mystery.
37. The personal officer asked if he could speak to the man. One of the perpetrators agreed and he removed the paper that was covering the door observation panel. When the personal officer looked into the cell he could see a figure slumped in a chair, tied up and covered with a blanket. The personal officer called out to the man but did not receive a response from him.
38. The duty governor became aware that the man had a heart condition and contacted the negotiation team to inform them. The negotiator told the two prisoners holding the man about the medical condition, one of whom was heard to say, "I wanted him dead anyway, he is just a nonce."
39. At approximately 5:53pm, the personal officer was able to obtain the perpetrators agreement to end the hostage-taking, but said they wanted a further 15 minutes thinking time before leaving the cell. The information was passed back to the command suite for a suitable surrender plan to be agreed and set up.
40. Seven minutes later, a perpetrator passed a home-made knife through the inundation point to the officer. The knife had been made using a plastic pen, razor blades having been melted into the plastic.
41. A surrender plan having been agreed with the commanders and the two prisoners having been told how the plan would work (including in which order the prisoners would leave), the cell was unlocked at 6:15pm. Both prisoners cooperated with staff and were escorted to the segregation unit without any further incident.
42. The PO was the first person to enter the cell. He removed the blanket that was still covering the man and saw him sitting on a chair. His arms were tied behind his back, and there were cuts to his arms and blood coming from his left ear. The man was alive, but unconscious and breathing with difficulty. The nurse entered the cell immediately after the PO and they both moved the man to the bed for further examination. Her medical examination concluded that the man was alive, unresponsive but breathing. She requested immediate medical assistance.

43. Two members of the ambulance service, who had been at the prison on stand by since the hostage-taking was discovered, responded very quickly. Their own examination showed that the man was in a critical condition and required an emergency transfer to hospital. He was taken by ambulance to hospital and placed on a life support machine, but later died without having regained consciousness.
44. Under normal circumstances, it is the prison's responsibility to inform next of kin of a death in custody or of an emergency admission to hospital. Unfortunately, the next of kin details contained in the man's prison record were not up to date. This meant that his next of kin were not immediately contacted and it was some time before they were told. I understand the prison governor is writing separately to the next of kin to apologise for their error. Additionally, the governor is implementing changes to the way next of kin information is recorded and will be asking all prisoners, on an annual basis, for these details.
45. Due to the serious nature of what had occurred, the Governor made available to his staff the support of the local and area care teams. That care and support has continued to be available to staff.

## ISSUES

46. The SIRs reporting that a prisoner was going to be stabbed were dealt with quickly. They were followed by a full assessment and instructions to staff to monitor the situation. Although I understand the wing manager was issued with an action sheet, I would have expected to see an entry in the observation book.

**The Governor should satisfy himself that there is an auditable recording system for communicating security assessment decisions to the appropriate staff.**

47. The duty governor went to the command suite (which also doubled as the intelligence office) to implement the contingency plans for dealing with a hostage incident, but the suite was not prepared for an emergency. Desks were covered with documents and the computer systems were not functioning. The contingency plans - the heart of managing any serious incident - were not readily available and had been packed into storage boxes. I need hardly say that this was very unsatisfactory, and very surprising in the context of a high security prison. Fortunately, the duty governor was sufficiently experienced to be able to open the suite and operate its systems correctly, and no harm was done.
48. Following a review of the incident, the Governor recognised that the location of the command suite had the potential to hamper significantly the effective management of a serious situation. He gave instructions to transfer the command suite to his office. However, I understand that this too is far from ideal, as it is very limited in terms of desk space and would in protracted incidents prove somewhat cramped, especially if all members of a serious incident were in attendance.

**The Prison Service High Security Estate should consider whether the location of the Full Sutton command suite is fit for purpose.**

## **CONCLUSIONS**

49. Although there was some information that the two prisoners who murdered the man were planning to stab someone, no-one had named him as the potential victim. It is possible that the man was simply in the wrong place at the wrong time. He may well have been the subject of an opportunist attack, and was too old to fight back and protect himself.
50. I am satisfied that the contingency plans worked well, albeit hampered by a command suite that was not ready for emergency use. I am pleased that the Governor quickly recognised the problem and has made interim arrangements to ensure such circumstances do not arise again.
51. I have been pleased to learn that the prison care team and staff welfare were quickly deployed to offer the necessary support.

## **RECOMMENDATIONS**

1. The Governor should satisfy himself that there is an auditable recording system for communicating security assessment decisions to the appropriate staff.
2. The Prison Service High Security Estate should consider whether the location of the Full Sutton command suite is fit for purpose.

## **ANNEXES**

Documents considered during the investigation:

1. Prison record
2. HM Chief Inspector of Prisons Report on Full Sutton
3. Anti Bullying Policy
4. Suicide Prevention Meeting
5. Violence Reduction Meeting
6. Probation Records
7. Life Sentence Plan
8. Parole Board Reviews
9. Discretionary Lifer Panel Reviews