

PRISONS AND PROBATION OMBUDSMAN

**Learning from PPO investigations:
Violence reduction, bullying and safety**

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Foreword



I took up post in September 2011 with an ambition to increase the learning of lessons from our investigations, not least those into deaths in custody. The commissioning and preparation of this report preceded my arrival but I am very pleased to introduce it. I believe it adds to our understanding of the impact of intimidation, bullying and violence on those who take their own lives in prison and offers some pointers to the National Offender Management Service (NOMS) which may help avoid future tragedies.

A previous report from this office showed that 20 per cent of our investigations into self-inflicted deaths in custody found evidence of bullying or intimidation from other prisoners. This does not mean that these prisoners took their lives solely because they were concerned for their safety. Indeed, the vulnerabilities that may make a prisoner susceptible to harm by others can make them susceptible to harming themselves. Nevertheless, these investigations often had a recurring theme: that improved recording and sharing of information relating to violence, intimidation and bullying was needed. In some cases, more reliable and thorough recording of information might have enabled a clearer picture to emerge of the risks an individual faced. In other cases, although information was recorded, it was not shared with those who could have usefully contributed to identifying and alleviating the problem.

A further related theme that emerged from these investigations was the need for intimidation, bullying and violence to be addressed more

holistically within prisons. Numerous examples were found where seemingly small pieces of information were known about a prisoner, but a lack of awareness of the relevance of this information meant that staff did not appreciate the important role that sharing it could play in improving an individual's safety.

The report begins by offering an overview of violence in custody, using recent official statistics, prisoner perceptions and reference to Prison Service policies. It moves on to consider how violence reduction features in fatal incident investigations, attempting to identify particular groups of prisoners whose safety in custody can be particularly at risk. The report then presents seven case studies that have engaged with the issue of violence reduction, so that the learning shared with the establishment in which the death occurred can also be shared with the wider readership of this report. A summary of lessons learned concludes the report.

I would like to thank my colleague, Mr David Ryan Mills, for preparing this report. It is the first in what I intend to be an increasing number of thematic publications produced in my tenure as Ombudsman.

A handwritten signature in black ink, reading "Nigel Newcomen". The signature is written in a cursive style with a long horizontal flourish at the end.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Executive Summary

- This report is focused on themes of violence, bullying and safety in custody. It has been produced as a result of the finding that 20 per cent of the PPO's fatal incident investigations into self-inflicted deaths in custody have found evidence that the deceased was subject to bullying or intimidation by other prisoners in the three months prior to their death.
- This finding is placed within the wider context of violence in prisons, by exploring official statistics and considering prisoners' own perceptions of safety. The national approach and local responses to violence in custody are then considered.
- Looking specifically at 42 self-inflicted death investigations, the PPO found that staff responses to allegations of bullying, assaults and other related incidents could have been better in 17 cases.
- The study found slightly higher proportions of self-harm history, mental health needs and suicide prevention measures at the time of death in cases where evidence of bullying or intimidation was found compared to cases where it was not.
- Whilst issues around bullying or intimidation by other prisoners were encountered more often in Young Offender Institutions (YOIs) and women's prisons, learning could be found across all functional types.
- Seven fatal incident investigations are summarised as case studies, with learning highlighted. The cases covered address specific themes including:
 - Dynamic security and collating security information about safety concerns
 - Implementation of local violence reduction strategies
 - Locating vulnerable prisoners
 - Approaching the subject of intimate relationships formed between prisoners
 - Abusive shouting through cell windows
 - Defining and investigating bullying
- The learning identified is categorised into three groups: the importance of recording and sharing information, improving understanding of violence reduction and the importance of protecting prisoners at specific risk of victimisation.

1. Violence and safety in prisons

1.1 Defining key terms

NOMS defines violence as ‘any incident in which a person is abused, threatened, or assaulted. This includes an explicit or implicit challenge to their safety, well being or health. The resulting harm may be physical, emotional or psychological.’ The PPO supports this definition, and the focus in this report is on any type of violent, intimidatory or bullying behaviour which may potentially impact on the safety of individual prisoners. This necessarily includes a wide range of behaviours, ranging from name calling through to the inflicting of serious physical violence.

It is crucial to clarify the importance of language around violence. The title of this paper includes the term ‘bullying’, a term that can be problematic in the prison setting, as the connotations of child-like behaviour can trivialise an important issue amongst prisoners. NOMS are clear that an assault or act of theft is both a criminal offence and a breach of prison rules, and should be managed as such. Should these acts be loosely termed as bullying, it may be harder for prison staff to challenge perpetrators, and there is the potential that their seriousness is undermined. However, in this report the terms ‘bullying’ or ‘bullying behaviours’ are not avoided. Fatal incident investigation work pieces together evidence from staff, prisoners and other sources to provide an account where the term ‘bullying’ is always seen as important, regardless of the operational difficulties that the term can present. Although the terminology in this report will at times refer simply to intimidation or bullying, this is simply for ease of reference and does not imply that only a narrow range of behaviours are being referred to.

1.2 Violence and safety in prisons – an overview

A recent report issued by the PPO¹ showed that 20 per cent of its investigations into self-inflicted

deaths found evidence that the deceased were subject to some form of bullying or intimidation by other prisoners in the three months prior to death, and it is these dimensions of violence upon which this report is primarily focused. To provide context to this finding an understanding of how safety in custody is measured and managed is required. This is best achieved by review of recorded assault rates, survey evidence of prisoners’ own perceptions of safety and the policy framework for the management of violence in prisons.

NOMS has a key performance target in respect of safety in prisons. In the 2010-11 annual report year this was met: the number of serious assaults² in prison were 1.65 per cent of the average prison population against a target of 1.9 per cent³. In real terms, this meant that there were 1,394 serious assaults recorded in 2010. The Ministry of Justice publishes detailed information on recorded assaults annually in the ‘Safety in Custody’ publication, produced in accordance with the UK Statistics Authority. These figures quantify one measurable aspect of violence in prisons and help provide the bigger picture of safety in custody. The most recent report tells us that in 2010:

- 14,356 assault incidents were recorded, fewer than the 15,185 recorded in 2009
- 1,394 of these were classified as serious (just less than 10 per cent), with 1,350 of these incidents occurring in male establishments and 44 in female establishments
- There were 2,856 recorded assaults on staff⁴

However, all measures to some extent rely on reporting, observation or detection, with much no doubt going on ‘under the radar’. In this sense, violence in prison (and elsewhere) is a ‘dark figure’ and all measures are merely ‘best estimates’.

¹ Prisons and Probation Ombudsman (2011) Learning from fatal incident investigations: Self-inflicted deaths in prison custody 2007-2009. Available at <http://www.ppo.gov.uk/docs/self-inflicted-deaths-in-prison.pdf>

² NOMS classify an assault as serious if it is a sexual assault, it results in detention in outside hospital as an in-patient, it requires medical treatment for concussion or internal injuries, the injury is a fracture, scald or burn, stabbing, crushing, extensive or multiple bruising, black eye, broken nose, lost or broken tooth, cuts requiring suturing, bites or temporary or permanent blindness.

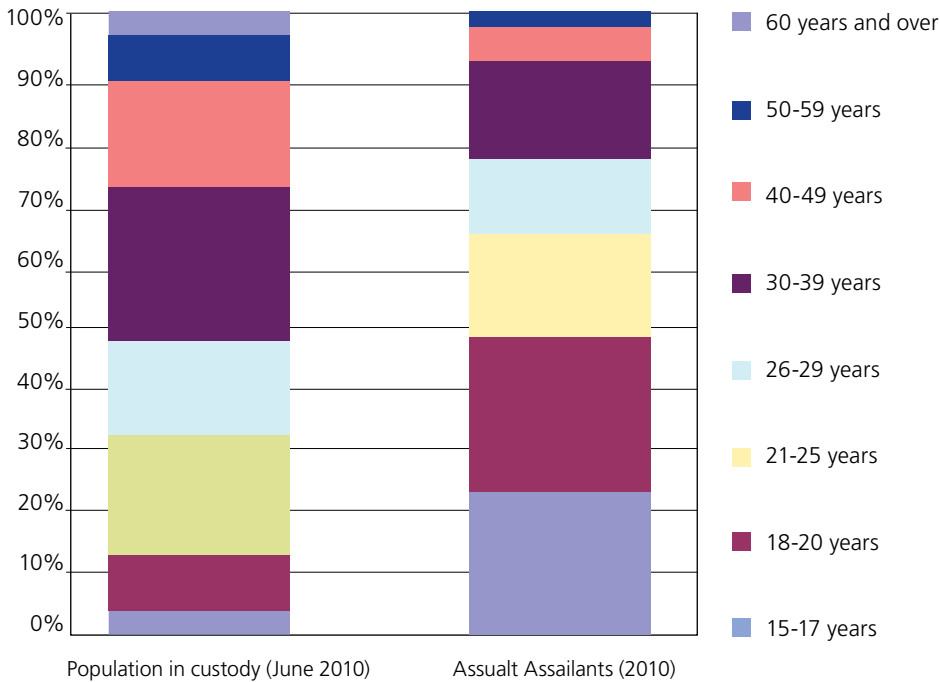
³ Ministry of Justice (2011): National Offender Management Service Annual Report and Accounts 2010/11 London: The Stationery Office.

⁴ Ministry of Justice (2011): Safety in Custody 2010: Ministry of Justice Statistics Bulletin 28 July 2011

Official statistics make clear that age is a key factor in determining where assault incidents are most frequent in the prison estate.

Figure 1 compares the age profile of the population in custody with the age profile of assault assailants in 2010:

Figure 1: Population in custody and assault assailants: Age comparison 2010

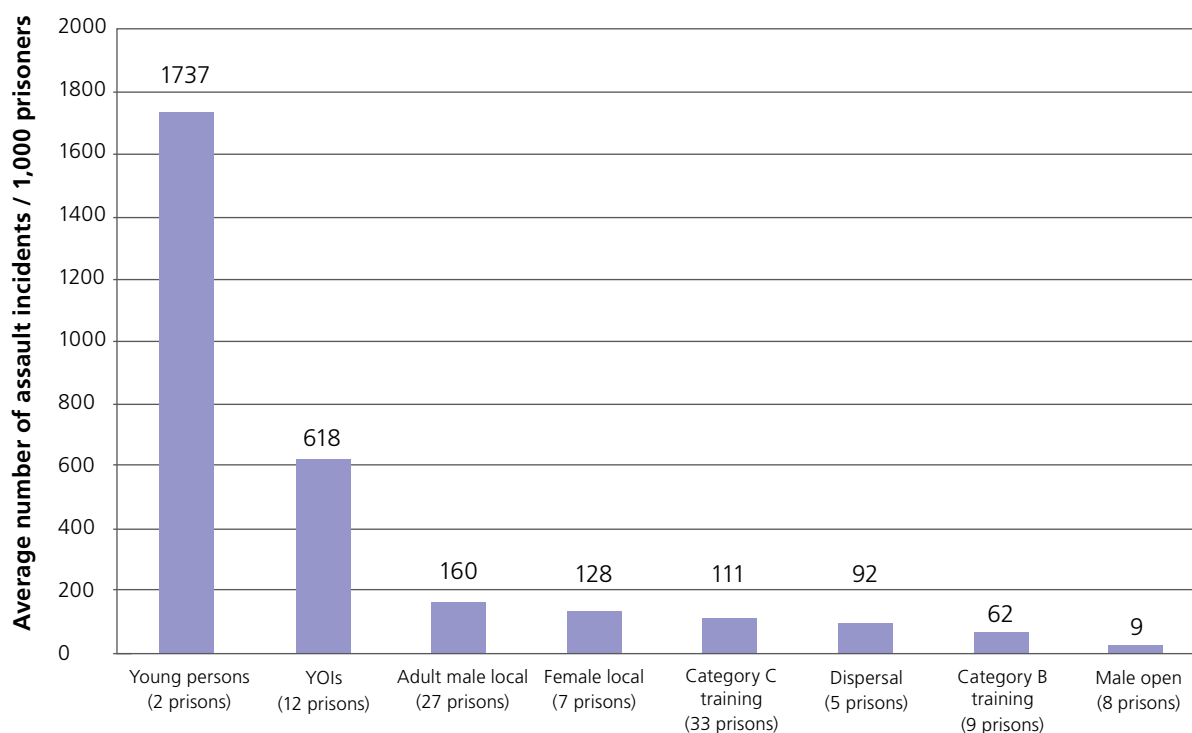


Those aged between 15 and 20 years old accounted for 12 per cent of the population in custody in 2010, but made up 49 per cent of identified assailants that year. In contrast, the largest group in custody are aged between 30 and 39 years old, making up 26 per cent of the population in custody, yet only 13 per cent of identified assailants.

It is useful to identify the types of establishment where assault rates are at their highest. Due to many establishments operating different functions for the prison estate (for example, HMP & YOI Norwich provides accommodation for Category B, C and D prisoners as well as young offenders), it has not been possible to

map all assaults recorded according to the functions each prison in England and Wales perform. Establishments which accommodate young people and young offenders have been particularly difficult to isolate and compare with official assault statistics, as many of them accommodate both under and over 18 year olds. Any which changed their function during 2010 have been excluded from this analysis; hence only two young persons' establishments are counted. Figure 2 draws an average assault rate per 1,000 prisoners for those prisons which, in 2010, were performing one exclusive function for the prison estate:

Figure 2: Assault rate per 1,000 prisoners: Establishment type (average for all establishments with exclusive functions in 2010)



Given that almost half of all assault assailants identified in 2010 were aged between 15 and 20 years old (Figure 1), it is of no surprise that assault rates are at their highest in establishments which accommodate children and young people (15-17 years) and young offenders (Figure 2). The rate of recorded assault incidents in open conditions is very low indeed. The Ministry of Justice does not publish details of assault incidents if fewer than six are recorded in an establishment. This was the case in six of the open prisons considered.

1.3 Prisoners' perceptions of safety

Prisoners' own perceptions of their safety are available from the HM Inspectorate of Prisons (HMIP), who survey prisoners prior to inspections, and also through NOMS' own Measuring Quality of Prison Life survey research reports. HMIP have recently reported that perceptions of safety vary considerably, even among establishments of the same functional type:

Figure 3: HMIP Surveys 2010-11: Responses to 'Have you ever felt unsafe in this prison?'⁵

Prison type	Highest %	Lowest %	Overall %
Local prisons	46	19	38
Category C trainer prisons	36	23	28
Young adult prisons	41	35	38
Category B trainer prisons	46	35	40
High security prisons	59	54	56
Open	23	10	17

⁵ HM Inspectorate of Prisons (2011): Annual Report 2010-11 London: The Stationery Office

It is unsurprising that prisoners in open conditions had the most positive perceptions of their safety. These perceptions appear to reflect the extremely low rate of recorded assault incidents in such establishments. However, HMIP survey responses show how perceptions of safety can often contrast with a relative rate of recorded assaults. YOIs, for example, may appear the most 'unsafe' from assault statistics, but prisoners' own perceptions across functional types did not reflect this. Perceptions of safety were at their lowest in the dispersal (or high security) prisons, despite the rate of recorded assault incidents being below the average for all types of establishments. The relative seriousness of assault incidents in both types of establishment may affect how such perceptions are formed.

The disparity between levels of perceived safety across the prison estate, and even within functional types of establishment, demonstrates how prisons have their own individual environment. Perceptions of safety can be dependent on environmental factors unique to each prison. Measuring Quality of Prison Life (MQPL) reports have indicated that staff willingness to intervene in violence can also impact on how safe prisoners feel, as can the frequency with which control and restraint techniques are used. The association of groups of prisoners, the design of a prison wing and the availability of drugs can also impact on perceived safety. Prisons therefore have to be flexible and responsive in managing safety and effectively implement evidenced policy that suits their local needs.

1.4 Responding to violence: National policy

In 2008, the Secretary of State committed NOMS to a policy of zero tolerance to violence, and in 2010, the Chief Executive of NOMS signed a Joint Statement with the National Chair of the Prison Officers Association (POA) to confirm this commitment. Whilst at first sight 'zero tolerance' appears to be an intangible step towards safer prisons, the agreement is symbolic of the national policy on violence reduction that was introduced in 2004. Prison Service Order (PSO) 2750: Violence Reduction, made it mandatory for every public sector prison to have in place a local violence reduction strategy. From mid-2007 this also applied to the contracted estate. The PSO requires each prison

to undertake regular analysis of their specific problem areas, consider solutions and provide an action plan to improve personal safety and reduce violence. The policy encourages a 'whole prison' approach to engage all disciplines of staff, as well as prisoners, in challenging unacceptable behaviour and improving personal safety. The policy directs prisons to consider environmental and physical measures (such as layout and visibility), as well as alternative ways of managing behaviour. Providing a prison can demonstrate it is appropriate for their needs, one aspect of their violence reduction strategy could involve anti-bullying measures. The vision behind the strategy is clearly documented:

'The Prison Service would like to demonstrate an active commitment to non-violence that is demonstrated by all who live and work in prisons. All staff and prisoners will contribute to and benefit from a safe, non-threatening environment for those who live and work in prisons.'

'Learning from past experience, good practice and working with others we aim to shape and refocus resources, to realise the potential of the Prison Service to contribute to a safe, non-violent society.'

PSO 2750 is not prescriptive in how violence is reduced in prisons. It is, perhaps, best referred to as a national 'strategy' rather than a national policy, as it promotes an overarching approach to reducing violence in prisons that is responsive to local needs. In January 2009, a review of the strategy commenced and at the time of writing one core Prison Service Instruction (PSI) is being developed. This PSI is to merge key elements of PSO 2750 with PSO 2700 (Suicide Prevention and Self-Harm Management) and PSO 2710 (Follow up to Deaths in Custody).

1.5 Responding to violence: Local policy

As necessitated by a non-prescriptive national approach, there is a wide range of local policies on violence reduction across different types of establishments. As demonstrated by official statistics, a YOI will have a very high volume of recorded assaults, and part of their policy may focus on the management of repeat assailants. In contrast, a high security prison will have far fewer, but potentially far more serious assaults. Here, for example, the local policy may place more emphasis on evidence gathering to assist

in police prosecutions. Similar establishments may also have quite different local policies due to the particularity of local needs, and disparity in available resources. For example, a prison with a psychology department may have a different policy to a similar prison without this resource.

Although there is very little in terms of prescriptive instructions within PSO 2750, there are some key elements for strategies to include. Local strategies must look to minimise violence through conflict resolution, dynamic security, problem-solving, effective risk management, addressing organisational and environmental factors, behaviour management for particular individuals, and offender management processes. Prisoners must be consulted about their views on violence reduction at least once a year, and strategies must also include the Prison Service definition of violence and a policy statement reflecting the ethos or vision of PSO 2750.

Importantly, the national strategy promotes an evidence-based approach and regular analysis of practice. This includes using information and intelligence about all fights and assaults to identify problem areas, and developing responsive action plans to improve safety. Prisons should also implement monitoring and evaluation procedures to measure progress, including the key performance indicator on serious assaults as a baseline. However, the Chief Inspector of Prisons notes in his annual report⁶ that data was not always effectively used to identify patterns and themes and there was often no training provided about local violence reduction procedures.

In recent years, NOMS has done much to support prisons measure their performance and use their data on violence effectively. Prisons have been encouraged to use local data (from assaults recorded to adjudication outcomes) and data available on the 'performance hub' to develop a richer picture of violence in their own establishments, as well as make appropriate comparisons between themselves and other establishments of a similar type.

When themes relating to violence reduction emerge in a PPO fatal incident investigation, it is the design and, more frequently, the implementation of the local violence reduction strategy that is explored in the investigation report.

⁶ *ibid.*

2. Violence reduction in fatal incident investigations

In June 2011, the PPO issued a report summarising key facts and figures from 206 self-inflicted deaths in prison custody between 2007 and 2009⁷.

A key observation made in the report was how frequently evidence of bullying or intimidation from other prisoners featured in investigation reports. This was found in 42 cases, 20 per cent of all cases considered. This chapter puts that finding into further context.

2.1 Violence reduction and self-inflicted deaths

That 20 per cent of self-inflicted death investigations featured evidence of bullying or intimidation from other prisoners is a statistic that can be interpreted in a number of ways. Academic studies have found that anywhere between five and 53 per cent of prisoners have been bullied whilst in custody, dependent on the definition and methodology used⁸. There is however a huge difference between how data can be collected in research and how evidence is acquired by the PPO before information on bullying is documented in an investigation report. In research, a common method of measuring bullying is by self-report or interview with prisoners, where a prisoner is asked (either directly or indirectly) whether they have been bullied or otherwise victimised whilst in custody. The very nature of a fatal incident investigation means the investigator does not have such an opportunity. Instead, the investigator has to report from available evidence that may include anti-bullying documents, security information reports (SIRs) and interview transcripts from staff or other prisoners. The threshold is higher than in academic studies and so a direct comparison between PPO investigation findings and survey research is unhelpful.

It can also be tempting to make a causal link between someone being bullied, intimidated or victimised and then taking their own life, though this temptation should be avoided. In most cases this would be too simplistic a leap: the very vulnerabilities that may make a prisoner

susceptible to harm by others can make them susceptible to self-harm. These issues can be very complex and often, common risk factors and other individual circumstances are of equal or greater significance than the fact that they were victimised by other prisoners. What cannot be disputed however is the potential impact of apparent bullying or perceived threat to safety on an individual's wellbeing, particularly when they may already be at risk of self-harm or suicide.

2.2. Exploring fatal incident investigations

The remainder of this report focuses on the 42 fatal incident investigations where evidence of bullying or intimidation was found. In a fifth of cases staff were unaware of the incidents of bullying or intimidation by other prisoners until after the death had occurred. Where staff were aware of the incidents, it was judged that the management of such incidents was wholly appropriate in around half of all cases. However, Figure 4 shows that for each case which was appropriately managed there was another case where room for improvement could be found - or more could have been done in nearly half the cases. The improvement suggested could range from an informal request that Governors remind staff of the importance of quality written entries on anti-bullying documents, through to a formal recommendation to revise elements of the local violence reduction strategy. Recommendations regarding violence reduction were made in half of the 42 investigation reports. Rather than repeat these recommendations here without any context as to why the recommendations were made in the first instance, key case studies highlighting common potential learning are presented in Chapter 3 of this report.

The 42 deaths where evidence of bullying or intimidation from other prisoners was found took place in a number of establishments performing several different functions for the prison estate (see Figure 5).

60 per cent of self-inflicted deaths investigated by the PPO have been in local prisons, reflecting their high population and throughput⁹. It is not surprising, therefore, that half the deaths where

⁷ op. cit. (1)

⁸ Ireland, J.L (2002): *Bullying among prisoners: Evidence, research and intervention strategies* Hove: Brunner-Routledge

⁹ op.cit. (1)

there was evidence of bullying or intimidation were in local prisons. Local prisons have a high turnover of prisoners, and instability in the prison population makes it more difficult to build up relationships between staff and prisoners. This, in turn, makes the recording and sharing of information all the more important.

Across all types of establishment, evidence of bullying or intimidation was found relatively more often in investigations into deaths in YOIs (and the one death in the young people's estate) and women's prisons than other prison types between 2007 and 2009 (see Figure 6).

Figure 4: Bullying or intimidation by other prisoners in PPO investigations (N=42)

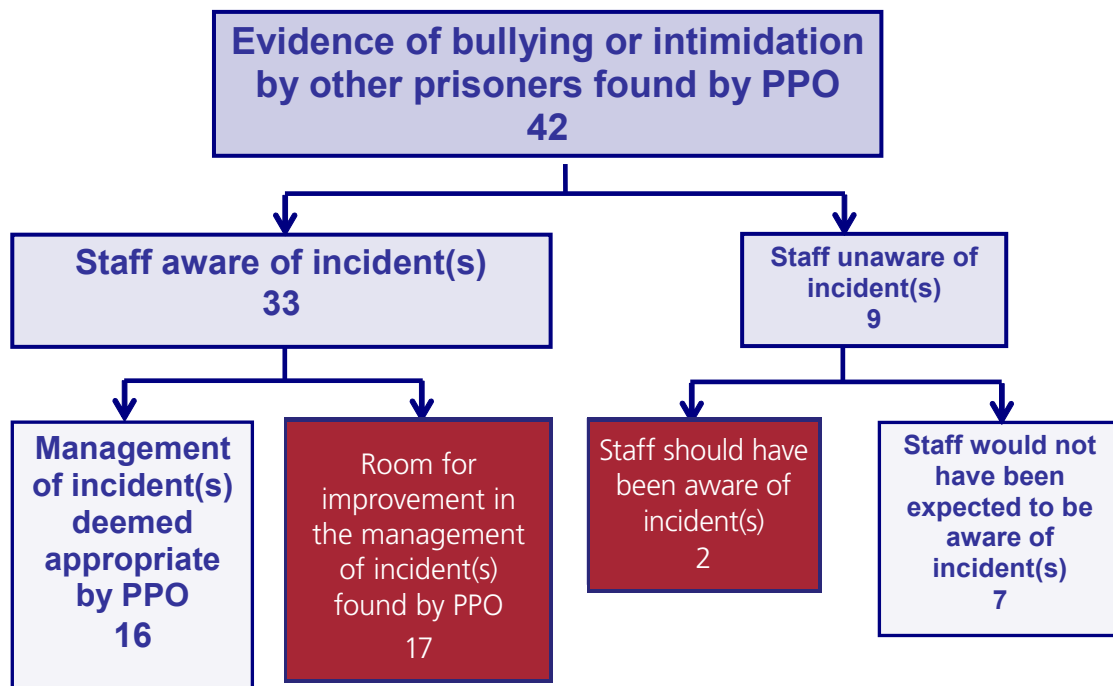


Figure 5: Evidence of bullying or intimidation found in self-inflicted death investigations 2007-09: Core prison function (N=42)

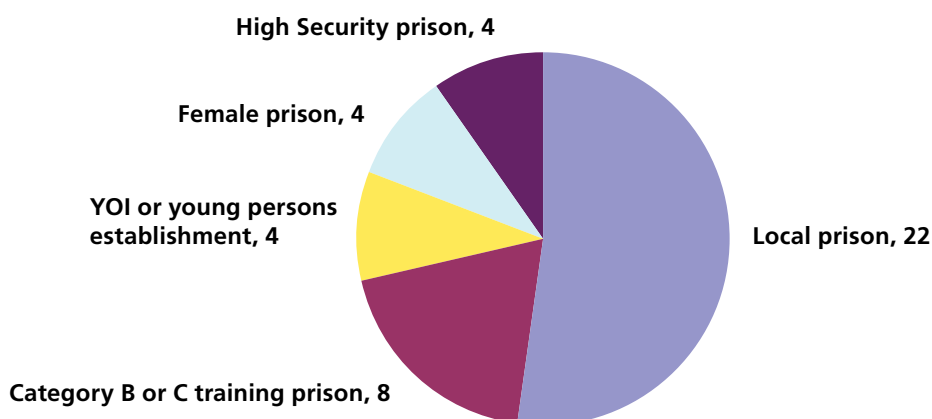
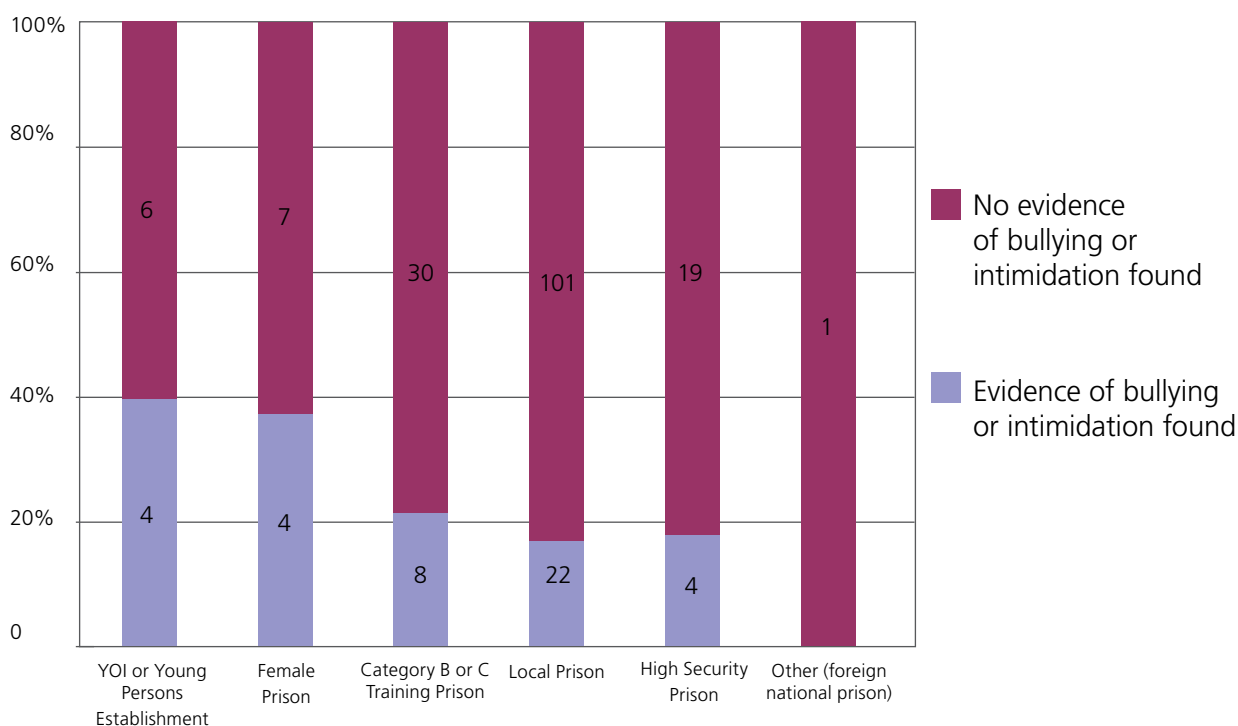


Figure 6: Evidence of bullying or intimidation found in self-inflicted death investigations 2007-09: Core prison function as a proportion of all investigations (N=206)



2.3 Prisoners involved in bullying

The leading academic researcher on bullying in prisons, Jane Ireland, has documented how approaches to identifying victims and perpetrators of bullying (with the intention of designing intervention strategies) have changed since the 1990's. Researchers have studied the perceptions held by staff and prisoners, the actual characteristics presented by those involved in bullying, the intrinsic characteristics of those involved in bullying and also the behaviours they display whilst in custody. Concentrating on victims, practitioners and researchers suggest the following characteristics can be indicative of those prisoners vulnerable to bullying:

- Characteristics indicative of vulnerability (such as size, stature and noticeable mental or physical defect)
- Characteristics indicative of being new to prison life (such as those on their first sentence, their first adult prison or otherwise naïve about prison life)
- Characteristics relating to the offence with

which they are charged (such as those who have committed sexual offences or offences against vulnerable groups)

- Prisoners isolated from their peers (perhaps from a different area of the country or otherwise unaccepted into previously formed prisoner groups)
- Intrinsic characteristics (including those with low self-esteem, passivity or limited problem solving skills)
- Behavioural characteristics displayed in custody (such as involvement in drugs, debt to other prisoners, regime engagement or place in a perceived 'hierarchy')¹⁰.

Whilst data on intrinsic or behavioural characteristics of the deceased is not routinely captured by the PPO, it is possible to identify whether or not some of the above characteristics were common in the 42 deaths investigated. It is also possible to identify whether the 42 individual cases where evidence of bullying or intimidation was found presented any different characteristics to those individuals where such evidence was not found.

¹⁰op.cit. (8).

2.4 Comparing investigations: Where evidence of bullying was found and where it was not

Key information from investigations where evidence of bullying or intimidation had been found (Group A: Evidence found) and those investigations where it had not (Group B: No evidence found) have been compared. It should be stressed that due to the small numbers involved no statistical significance can be inferred from these findings, they are merely illustrative. In terms of demographic profile, there was little difference between the two groups of investigations, though black or minority ethnic prisoners appeared to be over-represented in investigations where evidence of bullying or intimidation from other prisoners was found:

- The average of Group A (where evidence was found) was 33 years old as opposed to 35 years old in Group B (where no evidence was found)
- The proportion of foreign national prisoners in Group A was 21 per cent as opposed to 20 per cent in Group B
- The proportion of Black or Minority Ethnic prisoners was greater in Group A (29 per cent) than in Group B (16 per cent)

Whilst concerns about the mental health and vulnerability to self-harm and suicide were prevalent across both groups, slightly higher proportions of self-harm history, mental health needs and suicide prevention measures at the time of death were found in Group A (evidence found) than in Group B (no evidence found):

- The proportion of prisoners with mental health needs recorded in custody was slightly bigger in Group A (81 per cent) than Group B (76 per cent)
- The proportion of prisoners with a history of self-harm was slightly bigger in Group A (76 per cent) than in Group B (71 per cent)
- The proportion of prisoners subject to suicide and self-harm prevention measures at the time of death was, again, slightly bigger in Group A (38 per cent) than in Group B (35 per cent)

Again, while no statistical significance can be inferred from the findings above, it is interesting to note how often those who had been subject to bullying or intimidation were already identified by staff as vulnerable to self-harm and suicide.

In terms of offence and sentence history, there appeared to be a slight over-representation of prisoners who were in custody for the first time in Group A, as well as a slight under-representation of unsentenced prisoners too:

- Where evidence of bullying or intimidation was found (Group A) 50 per cent of the deceased were on their first custodial sentence. Where there was no such evidence found (Group B) the proportion was lower at 36 per cent
- No particular offence type was over-represented, with violent offences the index offence in 42 per cent of Group A and 39 per cent of Group B. The index offence was sexual in 17 per cent of Group A and 12 per cent in Group B
- There was a smaller proportion of unsentenced prisoners in Group A (33 per cent) than in Group B (51 per cent)

Part 3 now looks at seven fatal incident investigations in detail.

3. Case studies and lessons learned

In this final chapter seven fatal incident investigation reports are summarised. The summaries focus on themes related to violence reduction policies, with a discussion on lessons

learnt in each case. Other recommendations and issues were covered in investigations but this chapter only covers those that related to violence reduction. Rather than attempt to be representative of all deaths investigated, the reports are chosen to offer the full spectrum of issues encountered across the prison estate and in particular functional types of prison.

Case Study One: Collating security information and dynamic security (Category C training prison)

Mr A was serving an indeterminate sentence with a minimum tariff of 2 years, his first custodial sentence. At the time of his death he was 25 years old, and had spent just over three years in custody. His offending had been linked to his alcohol consumption, which he may have used to mask anxiety issues that had been diagnosed in the community. Whilst in custody, he began to use illicit drugs. This hampered his progress towards release and left him in an uncertain situation. In addition, his father had died whilst he was in custody. Despite this, Mr A's death came as a shock to staff and those who knew him. Indeed, this was the first self-inflicted death to have occurred in the establishment for many years.

Mr A's family was concerned that due to his age and lack of understanding of prison life he was vulnerable to manipulation and bullying from other prisoners. These concerns were shared by prison staff who believed that other prisoners were leading him astray. Prisoners that had known Mr A confirmed that he had been targeted by others, who saw him as a 'soft touch' and were allegedly supplying Mr A with illicit drugs.

Due to information that was being submitted in security information reports (SIRs), anti bullying measures were initiated on several occasions. Reports indicated that Mr A had been targeted by other prisoners, was in debt and that he could have been at risk of violence. Other prisoners were also concerned that Mr A had given away a number of his personal items. However, they did not share their concerns with staff, preferring to deal with issues 'in-house' instead of 'grassing'. Matters were complicated as Mr A would not admit to being bullied when staff offered their support. These attitudes, although not unusual, made it difficult for staff to build a picture of what was happening with Mr A and challenge perpetrators of bullying.

Despite the denials made by Mr A, the investigation judged that the prison had failed to effectively collate security information that mentioned Mr A or act upon it. Additional information concerning drug supply and the circumvention of drug test procedures on Mr A's unit were not considered as part of the bigger picture of his, and possibly other prisoners' safety, whilst in custody.

In Chapter 1, it was noted how the use of dynamic security (involving staff working with prisoners to understand activity on the wing) should be promoted in all violence reduction strategies. In Mr A's case, the investigation heard that staff shortages meant that officers could not get out and about on the unit as much as they would like. These constraints were also blamed for a lack of effective cell searches that may have confirmed other prisoners' suspicions that Mr A had property missing as a result of accumulated drug debt.

The availability of drugs within a prison or a particular wing or unit compromises safety in custody. In 2008-09, HMIP found that in the Category C estate, prisoners' perceptions of safety depended a great deal on size and the availability of drugs¹¹. No recommendation was made about the availability of drugs in Mr A's case due to progress already made

by the prison. However, the following recommendations were made by the PPO, and both accepted and implemented by the prison:

- The Governor should issue a Notice to Staff reminding them of the anti-bullying procedures and the importance of using other resources such as cell searching to identify possible bullying activity.
- The Governor should ensure that, where necessary, information relating to a particular unit is shared with the staff so that all prisoners or others that may be at risk can be monitored and supported.

The prison also agreed to conduct a 'spot check' of how security information is handled and followed up. The role of security departments in helping ensure the safety of vulnerable prisoners is explored in case studies two and three.

Case Study Two: Security issues as safety concerns (Category C training prison)

Mr B was a foreign national prisoner aged 21 at the time of his death. He had served 18 months of a six and a half year sentence in three YOIs and two adult prisons. He was a difficult prisoner to manage, having been involved in several altercations with other prisoners. He had a history of self-harming by ligature and was known to have stopped using the mood-altering medication he had been prescribed. In addition, worries about the state of his relationship with his partner appeared to distress him immensely.

Whilst Mr B displayed a number of risk factors, he was not considered by staff to be at any immediate risk of self-harm or suicide. Investigation suggested that communication with his partner and the issues faced on his wing may have triggered his final act of self-harm.

According to a fellow prisoner, Mr B was 'easily wound up', particularly with regard to his partner. Mr B had illicitly acquired a mobile telephone while in prison. This was stolen by another prisoner which greatly agitated him. It appears that Mr B had used the mobile telephone to contact his partner and his subsequent inability to do so caused him distress. This was added to by other prisoners apparently using the mobile telephone to contact and abuse Mr B's partner. He was involved in a number of incidents with the prisoners he believed to be the perpetrators. The fellow prisoner said that he would get very wound up over any problem with his partner and "the whole wing would hear about it".

Prison staff filled out a number of SIRs regarding Mr B's loss of his mobile telephone and the effect this had on him. Cells of the suspected perpetrators were searched by staff but the device was not located. Mr B was also moved in an attempt to separate him from the prisoners he was in conflict with. After trying and failing to contact his partner on the eve of his death, Mr B was found hanging by staff on the night shift.

¹¹ HM Inspectorate of Prisons (2010): Annual Report 2008-09 London: The Stationery Office

Case Study Three: Implementing local policy (Local prison)

Mr C was a remand prisoner charged with offences against the person. He had been in custody for just over three months, including a short time spent on bail. It was not his first time in custody. He had been identified as posing a risk to himself and was being monitored under the prison's suicide and self-harm procedures at the time of his death.

Two months after his arrival, staff completed a security incident report (SIR) when a telephone conversation suggested his wife was planning to bring mobile telephones into the prison during a visit. Staff suspected that Mr C and his wife were trafficking items on behalf of other prisoners.

A month later, Mr C alleged that a prisoner on his wing was pressuring his wife to bring drugs into the prison. He also said that a number of prisoners on the wing were bullying him. Staff recorded details of the allegations, again on an SIR and Mr C was moved to another wing. The officer who completed the SIR said he telephoned staff on both wings to inform them of the situation. A week later, Mr C repeated the allegations to his substance misuse worker. He said that he did not want to return to his previous wing for "fear of repercussions". A second SIR was completed and staff on his new wing were informed.

Investigation also found that Mr C may have been pressured for his prescribed medication. Staff on his previous wing were not aware that Mr C had complained of being bullied. They had not noticed any prisoners bullying Mr C and were not aware he may have been under pressure for his medication. Two weeks before his death, Mr C was transferred back to the wing where he had experienced these difficulties.

According to the SIR document, an allegation of bullying should result in the notification of relevant staff, including wing staff, the suicide prevention co-ordinator and the violence reduction co-ordinator. In addition, the relevant wing observation books should be updated. In Mr C's case, none of the relevant staff had been informed of Mr C's allegations and the wing observation books had not been updated.

Regarding the illicitly acquired mobile telephone and its subsequent theft, the prison's Safer Custody Manager told the investigator that such incidents were, at the time, deemed to be predominantly security concerns and dealt with as such. However, it was explained that this approach had now changed. Given the capacity for the use of mobile telephones to involve drugs, coercion and harassment, as well as the knock-on effects such as debt and intimidation that contraband can bring to prisons, the Safer Custody Team is now informed of all SIRs of this nature.

Due to the action that had been taken, no formal recommendation was made. This change in local policy is to be welcomed, and the experience can usefully be shared with other prisons.

In Mr C's case, the prison had a well-established violence reduction strategy, which relied on staff monitoring and supporting both the victims and perpetrators of bullying. However, the procedures for informing staff and updating both the prisoner's file and wing observation books were not followed. There was no evidence that Mr C was offered any specific support in the light of his allegations, or that any detailed investigation into their substance was carried out.

The most perfectly designed policy can quickly become worthless if staff do not implement it. Whilst a different course of action may not have prevented the death of Mr C, the investigation demonstrated that other prisoners could not be fully confident in the violence reduction strategy when reporting allegations of bullying.

The following recommendation was made:

The Governor should put in place procedures to ensure that when allegations of bullying are made:

- Relevant wing staff and the violence reduction co-ordinator are informed, and

- Relevant wing observation books and prisoners' files are updated when allegations of bullying are made.

The recommendation was accepted, and the prison agreed to ensure all relevant areas are passed key information.

Case Study Four: Locating vulnerable prisoners (Local prison)

Mr D was remanded into the custody of a local prison, charged with a sexual offence committed against an adult woman in his small community. It was not his first time in prison and he had been in that prison before. However, his previous offences had not been of a sexual nature. Other men from his community were also in the prison and some subscribed to their local newspaper that had featured details of the offence and Mr D's arrest.

Mr D spent the next seven days in the first night centre, where he spoke to many staff about whether or not to ask for vulnerable prisoner (VP) status. Prisoners may request VP status and be accommodated in a separate unit, where available. This can be for a number of reasons but, as many other prisoners disapprove strongly of sexual offences, those that have committed these types of offences may be vulnerable to victimisation from other prisoners.

Mr D accepted that he needed the relative safety of the VP unit but showed extreme reluctance to go there. Twice he asked for VP status, only to change his mind before being allocated a place in the unit. He told an officer he did not want to be "branded" a VP, as the stigma would stay with him throughout his imprisonment. Neither did he want the other prisoners from his village to learn that he was a VP. He appeared unwilling to classify himself, and be classified, as a VP.

A second issue was that Mr D did not want to share a cell with a sex offender and he had told two members of staff that he did not want to do so at reception. In the VPU, he would have lived and worked alongside such men - for many years, if he had been convicted of the charges he faced.

Six days after arriving at the prison, Mr D moved to one of the normal wings at approximately 6.00pm. The agreement to remove him from VP status was given without a manager discussing the decision with him. Within 30 minutes, the other prisoners had identified him, and the charges he faced, from his picture in the local newspaper. A group went into his cell and assaulted him, causing superficial injuries to his face and shoulders. Staff quickly stepped in and escorted him off the wing. As they walked towards the door, prisoners gathered and verbally abused him.

Mr D told the officer escorting him back to the first night centre that "I knew this would happen, but I thought I would give it a go - coming to normal location." A nurse examined his injuries, which did not require treatment. Several other staff spoke to Mr D and he reassured all of them that he was fine. None of them had any concerns about him and an ACCT was not opened. At 1.00am the following morning, Mr D was found hanging in his cell and he died two days later in hospital.

Whilst Mr D's injuries did not require treatment, the clinical reviewer appointed to assess Mr D's healthcare noted that it would be helpful to conduct a mental health assessment following an assault and the following recommendation was made:

The Head of Healthcare should ensure that a brief mental health assessment is completed and the findings recorded after a prisoner has been assaulted.

The prison agreed that serious or offence related assaults should trigger a mental health assessment and an action plan was devised.

How prisons locate vulnerable prisoners can have a knock on effect on the management of an entire establishment. Separating vulnerable prisoners from the main population in a unit or wing requires the provision of separate regimes, separate visiting arrangements, separate arrangements for education and so on. It should be noted that the safety such units provide is relative – victimisation may be just as likely to occur between vulnerable prisoners on a separate regime as it is on normal location. The Chief Inspector of Prisons noted in his 2010-11 annual report¹² that prisoners who were vulnerable or needed protection from others had more negative perceptions about

their safety and, in some cases, their access to the regime was restricted. There is also the potential problem of stigmatisation, clearly a concern in Mr D's case. Some prisons run what can be described as a 'non-collusive regime', whereby a 'vulnerable prisoner' population is not recognised as such. Those considered to be vulnerable are integrated into the same regime as far as possible, with particularly vulnerable prisoners managed with as little stigmatisation as possible.

These complexities necessitate a considered approach when a decision regarding the location of a vulnerable prisoner is required. In Mr D's case, his request to go to normal location was not discussed with a manager but rather he was asked to sign a disclaimer (that had no legal standing) stating he accepted the risk involved. The investigation recommended that:

The Governor should ensure that all prisoners requesting to move from the vulnerable prisoners unit to normal location are interviewed by a manager before a decision is taken.

The recommendation was accepted. The disclaimer was removed and procedures were changed to ensure all such prisoners are interviewed by a manager.

¹² op.cit.(5)

Case Study Five: Relationships between prisoners (Women's prison)

Ms E had been in prison for over 12 years at the time of her death and was working towards transfer to open conditions. The Parole Board identified psychological interventions that were necessary prior to such transfer, but unfortunately these were hindered by a lack of resources. Whilst this frustrated Ms E, she was not considered at risk of suicide by staff and her death came as a shock to all those who knew her.

Whilst in custody, Ms E developed a relationship with another prisoner. Both staff and prisoners commented that this was a very volatile relationship – indeed, Ms E disclosed to a member of staff that the other prisoner had been violent towards her. However, the allegation was not investigated in line with the prison's violence reduction strategy and the information was not recorded on an SIR. Three months prior to her death, Ms E moved wings and employment at the prison, seemingly to have more time to herself. A week or so before Ms E died, the other prisoner was moved onto the same wing as her.

The majority of staff of all grades and disciplines seemed to be aware of the relationship between the prisoners - though not those on the wing that Ms E was transferred too. Most staff who knew commented that they did not believe it to be a positive relationship and were concerned for the two women's welfare at some point. Little was done to challenge the two prisoners regarding the negative elements of their relationship. Evidence of their volatile relationship was held by individuals rather than being recorded centrally for all to share. This resulted in staff on the new wing not being aware of either the relationship itself, or the concern expressed by staff on her previous wing when - at the request of Ms E - the other prisoner transferred.

Ms E was found hanging in her cell by staff. In her police statement, the prisoner with whom she had shared a relationship admitted to having been violent towards her the night before she died.

The Governor should remind staff of the contents of the violence reduction strategy policy including the need to report, record and communicate all incidents of violence and act on these as appropriate.

With regard to the relationship between Ms E and another prisoner, the prison's own decency policy stated that intimate relationships between prisoners are not condoned, and should such a relationship be identified it should be discussed with wing managers immediately, with appropriate action taken. This stance is taken due to the potential tension relationships can cause within the prison, that can lead to difficulties when relationships break down.

It is noted that some relationships women can form in custody are extremely difficult to manage. They can be sexual, exploitative or cultural, and can involve bullying or, effectively,

domestic violence. Moreover, some relationships can be hard to identify, define and distinguish from what can otherwise be considered as close companionship. Whilst the local policy was deemed to be sound, staff had identified friction in the prisoners' relationship and did not challenge it in a co-ordinated manner. As a result, the investigation report recommended:

The Governor should ensure that staff are clear when and how to challenge relationships between prisoners, particularly when it is evident that there is friction.

The recommendation was accepted, and both the safer custody and decency policies were updated to ensure staff are clear of their role in respect of apparent relationships between prisoners. The issue of relationships formed by women in prison had received attention by the PPO prior to this case. Since 2008, five published

investigation reports have commented on the issue. As a result of an investigation in 2007, a national recommendation was made urging the Prison Service to consider training violence reduction co-ordinators in how to identify and manage bullying caused as a result of relationships between prisoners.

The recommendation was accepted and it was noted that a women's awareness staff programme (WASP), that included elements relating to prisoner relationships, was being piloted at the time. The continuation of these efforts is promoted by the Ombudsman.

Case Study Six: Shouting through windows (YOI)

Mr F was a foreign national prisoner aged 20 years old. He was due for release from prison a week after his death and was not likely to face deportation.

After four months without incident, Mr F reported that he was being bullied by other prisoners on the wing who were shouting at him through their cell windows. He told staff that he was particularly worried about being targeted by other prisoners after his release. Staff started suicide prevention monitoring in the days before his death. Reluctant to leave his cell, he collapsed while collecting his meal and was taken to hospital where he was diagnosed with dehydration. Upon his return to the prison that evening, staff increased the frequency of observations, only to reduce them again the following morning. Later that day, Mr F was found hanging in his cell.

The PPO investigation found that in response to the allegations of bullying through windows, Mr F was moved to a quieter area of another wing. Suicide prevention monitoring began when he reported to staff he was subject to similar shouting through his windows in his new location, and as a result he would 'die in this prison'. The situation was complicated by the difficulty in identifying perpetrators of abusive shouting through windows, the possibility that Mr F's limited understanding of English lead him to misunderstand the shouting. Staff were also concerned that Mr F may have been suffering mental health symptoms and the voices heard may have been in his head.

Whilst the decision to open an ACCT document was wholly appropriate, it was considered that the prison did not do enough to investigate the allegations of bullying.

An SIR was not submitted and measures from the prison's well-established violence reduction policy - that confirmed shouting through windows can be considered as bullying - were not implemented.

Following investigation into the death of Mr F, the following recommendations were made by the PPO, accepted by the prison and implemented by staff:

The Governor should audit the reporting of bullying through windows and satisfy himself that it is being dealt with appropriately.

The Governor must remind his staff of the importance of SIRs when managing challenging behaviour.

This was not the first fatal incident investigation that identified shouting through windows as a particularly difficult issue to manage in prisons. Not unsurprisingly, PPO investigations have encountered such behaviour almost exclusively in YOIs. When the prison in Mr F's case integrated the YOI and adult parts of the prison, a marked reduction in the incidence of shouting through windows was observed. After the tragic death of a juvenile in custody in 2007, awareness of the issue of abusive shouting through windows increased, and NOMS addressed the issue in part through the publication 'Safer Custody News' (no longer circulated by NOMS). The first hand experience of PPO investigators indicate that managing such behaviour can be particularly problematic in night state, when few staff are available to either identify or challenge perpetrators. Shouting through windows, whether intended as abuse or not, can cause immense distress to victims as well as other prisoners. The Ombudsman considers that in response to shouting through windows a zero tolerance approach is warranted - staff should aim to identify and challenge perpetrators of abusive shouting and support victims where appropriate.

It is acknowledged that cell and wing design can contribute to the extent of the problem, and it is worth reminding the Prison Service of a national recommendation first issued in 2009:

Consideration should be given to the installation of new cell windows in any unit that experiences increased levels of shouting, to reduce the ability of the occupants to taunt each other.

Case Study Seven: Defining and investigating bullying (YOI)

Mr G was recalled to prison 15 days after completing the custodial term of an 18 month sentence, after failing to adhere to the conditions of his licence. He was transferred twice, moving from the London area to the South West and finally, the East Midlands. He had been in his final establishment for two months before an officer found him hanging in his cell.

Mr G had harmed himself on a number of occasions whilst in custody and was subject to additional monitoring on several occasions, though, at the time of his death, he was not considered to be at imminent risk. Throughout his time in custody, staff were clearly concerned about his well-being, and found it difficult to effect a sustained improvement in Mr G's mood. For much of the time he was deeply unhappy, and seemed to struggle to find any relief from his ongoing depression. He was a vulnerable young man who, when low in mood, spent a lot of time by himself. At a previous prison during the same spell in custody, he was assaulted by three other prisoners. Two days later, he harmed himself, and said he had never felt worse and wanted to die. During the last few weeks of his life, members of staff at his new prison noticed that Mr G became increasingly withdrawn, spending much of his time in his cell.

The day after Mr G's death, staff became aware of speculation amongst prisoners that he had been bullied, and that this might have caused him to end his life. The prison conducted a simple inquiry, and three other prisoners were removed from their trusted positions as servery orderlies. The inquiry made no conclusive finding about whether or not Mr G had been bullied, although the prisoners admitted that some altercations had taken place.

The PPO investigator interviewed four prisoners who had lived on the same unit as Mr G at the time of his death. The interviews resulted in a mixed picture of what happened. One prisoner said he had personally witnessed Mr G being bullied by those working on the servery. He said they had given Mr G smaller portions of food, banged on his cell door, and humiliated him. Another prisoner gave a similar account, though he had not personally witnessed anything and had heard about it from others on the unit. However, other prisoners were not convinced that Mr G had been bullied. One of them said interactions between Mr G and the servery orderlies were good-humoured, apart from one incident that was resolved quickly. The other prisoner said allegations of bullying were entirely false, and had been invented by a prisoner on the unit after Mr G's death.

It was impossible to be certain about exactly what happened between Mr G and the servery orderlies, how he might have felt about the altercations that took place, and whether their interactions were malicious or in jest. The fact that the allegations were made after the death complicated matters further, because the information could only be analysed retrospectively. The prison had a policy relating to violence reduction and bullying, but with no allegations made whilst Mr G was alive, he was not subject to any anti-bullying procedures. Prior to Mr G's death, there were no reports of bullying or intimidation, and nothing of that nature was recorded in his wing history file or the unit observation book.

It is easy to imagine the way in which a rumour can circulate amongst prisoners, and indeed some of the information obtained during the interviews with the prisoners was second hand rather than directly witnessed. Nevertheless, the fact that there were some incidents is undisputed. Mr G spent much of his time alone, was very low in mood, and found it difficult to socialise with other prisoners. It does not necessarily require a sustained campaign to make someone who is already vulnerable feel that they are being victimised.

Members of staff need to be alert to the possibility that a prisoner might feel victimised even if that is not the intention of other prisoners. No formal recommendation was made in this area. However, the prison was asked to remind staff that seemingly minor altercations might be more powerful when directed at someone who is vulnerable or withdrawn from the regime.

4. Lessons learned and implications for practice

The seven case studies above demonstrate a number of learning points. This final section of the report summarises the themes that have emerged and the resulting implications for practice.

The importance of recording and sharing information about bullying or victimisation

In several of the case studies there are examples of information being collated about the prisoner who died. On many occasions SIRs were submitted and there was usually awareness amongst several members of staff of suspected difficulties the prisoner was encountering. However, there were also many examples of the threads of this information not being coherently drawn together. In some cases, it appeared that if someone had been in possession of all the information available about the prisoner, it would have been possible to piece together a comprehensive picture of the issues they were involved in and how this may have impacted on their safety and well-being.

The reality of many prisons is that they are busy and tightly resourced, and it is not difficult to understand how occasions arise when important information does not reach the staff that need it. However, prisons need to ensure that adequate systems are in place to counter this. The robust recording and sharing of information is crucial if staff are to have the opportunity to assess an individual's particular vulnerabilities and to put in place support to reduce any risks.

Prisons could benefit from considering the following learning points in respect of their own establishments:

- Is your approach to recording and sharing information on allegations of bullying or incidents of violence sound? Are wing history sheets / observation books / P-Nomis consistently updated with quality entries?
- Is your safer custody department informed of appropriate security information that can impact on the safety of particular prisoners?

- Are alternative measures (such as cell searches) used to identify possible bullying activity?

Improved understanding of violence reduction and how to improve prisoners' feelings of safety

The national violence reduction strategy makes clear that violence reduction and safety are concerns for everyone within a prison and they should not simply be seen as matters for the security or violence reduction staff to deal with. An improved understanding of every aspect of a prisoner's individual risks can ensure appropriate support is provided. If, for example, a prisoner has become involved in drugs within the prison it is important for staff to understand the implications for that prisoner's safety and to take this into account when assessing how to support any other vulnerabilities.

It is also crucial that prisons have reliable processes to draw together the knowledge of staff working across the different disciplines within the establishment. Staff within offender management and psychology departments often have a wealth of information about a prisoner's previous behaviour or individual risks which may affect the support that they should be offered.

The following learning points may be helpful to prisons when considering their own practice:

- Does your violence reduction strategy make full use of your psychology and offender management department?
- Do staff in your establishment understand and use the Prison Service definition of violence, to ensure that they know how to deal with the broad range of behaviours that encompass interpersonal violence between prisoners?
- Does your violence reduction strategy ensure that relevant staff are aware of allegations of bullying or incidents of violence (such as violence reduction co-ordinators, wing managers and personal officers)?
- Is dynamic security used effectively and consistently in your establishment?

The importance of protecting prisoners at specific risk of victimisation

There will always be prisoners who are at heightened risk of victimisation. In this respect, this report has focused on vulnerable prisoners, who can be at specific risk within the main population of a prison. The need to balance an individual's desire not to be stigmatised by their offence with the need to protect them from victimisation, can be a difficult challenge for staff. However, the decisions over where to locate vulnerable prisoners must be informed by all the information available and the over-riding responsibility to protect their safety. Staff also need to be equipped to know how to manage prisoners who may deny that they are being victimised in order to avoid further stigmatisation.

The following learning points have been identified and may be useful to establishments in reviewing how they locate vulnerable prisoners:

- Does your anti-bullying strategy remain effective if a prisoner denies being bullied?
- Do serious or offence-related assaults trigger a mental health assessment for the victim?
- Are prisoners requesting transfer from your vulnerable prisoner wing / unit to normal location interviewed by a manager before a decision is taken?

4.1 Concluding remarks and moving forward

Much has been learnt in this brief study of violence reduction, bullying and safety in prisons. It should be stressed that by and large prisons are safe places, and staff do well to ensure the safety of a large and difficult population. Similarly, we should not forget that deaths directly related to violence and associated behaviours remain relatively rare, although in one in five cases the person who took their life had experienced some form of victimisation prior to their death. Nevertheless, each fatal incident investigation that tackles these issues provides learning for establishments, learning that is usefully shared across the prison estate.

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