

**Final Report of an Independent Investigation
into the Case of Mr North**

**commissioned by the Secretary of State for Justice
in accordance with Article 2 of the European
Convention on Human Rights**

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April 2016

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EXECUTIVE SUMMARY

In December 2001 Mr North was sentenced to life imprisonment and a concurrent term of 12 years imprisonment. In February 2002, he received a further six life sentences, two concurrent terms of four years and a further concurrent sentence of one year. He has a long history of violent offending which had previously resulted in periods of imprisonment for a variety of offences. He is not a man who has only been exposed to violent offending since being sent to prison. At his most recent sentencing the Judge described Mr North's record as one of "*appalling gratuitous and indiscriminate violence*".

After sentencing, Mr North returned to HMP Belmarsh and was then sent to HMP Whitemoor on 11th September 2002. Throughout the period of imprisonment, Mr North was a problematic offender. In order to assist with managing his behaviour and impact he was moved around the High Security Prisons on a regular basis. During this period of imprisonment, Mr North accumulated 42 proven adjudications for breaching a variety of Prison Rules. His offences against prison discipline included assault, possession of weapons and possession of drugs. He presented staff with significant challenges.

Mr North was received at Whitemoor on 3rd July 2008 on transfer from HMP Full Sutton where he had spent the previous eight months. This was his third period at Whitemoor since sentencing in 2002. His transfer was arranged to enable him to be located on a wing rather than be held in Segregation where he had spent the last three months of his time at Full Sutton. His solicitors at the time, Legal Practice 1, had campaigned

vigorously to have him returned to normal location. In late June 2008, they had begun the process of application for a Judicial Review of the decision to keep Mr North in Segregation.

After completing the reception process at Whitemoor, Mr North was located on Blue Spur of C wing. From then on he was involved in the normal routine of that wing. Towards the end of the evening period of Association when prisoners are allowed free movement around their spur, there was a disturbance on another spur of the wing which was nothing to do with Mr North and in which he had no involvement. Staff arrived on the wing from other parts of the prison to deal with the incident and all prisoners were required to return to their cells. Mr North took the opportunity to refuse to return to his cell, saying he would rather be taken to Segregation for the night. In the face of Mr North's continued refusal to move, staff used Control and Restraint techniques to remove Mr North from the wing and take him to the Segregation Unit.

The following day, Mr North was charged with refusing to return to his cell and when the charge was heard, he said that he had refused to go to his cell because there were other prisoners on C wing that he could not associate with. He was relocated to A wing, Red Spur on July 5 2008. Governor 4 carried out the adjudication.

Mr North continued on A wing, apparently without problem, until July 22nd 2008. On that day he went to the first afternoon session in the gym. It seems that this may have been the first time that Mr North left the wing. As the session was about to end, Mr North was attacked by a number of other prisoners and sustained a head injury. When the physical education staff arrived, there was no obvious sign of who had carried out the attack. Mr North never identified anyone, saying that he did not see the attack coming and did not know who carried it out. When asked, he stated that he did not want any investigation of the incident.

Mr North was provided with treatment for his injuries in the Healthcare Centre, the next gym session was cancelled whilst the necessary processes were attended to and then at 16.45 hours Mr North was located in the Segregation Unit for his own protection, under Rule 45 of the Prison Rules. The Duty Governor, Governor 6, was clear that Mr North would be at risk if he were returned to a wing.

Immediately following the attack in the gymnasium on 22nd July 2008, Mr North clearly had an opportunity had he wished to do so to identify his attackers to the Physical Education Officers. It can be argued that Mr North could and should have done more himself to assist prison staff in managing the ongoing risk to his welfare. Mr North made the task of those charged with managing any ongoing risk even more challenging by initially informing them that he had suffered an accident and then refusing to support an internal investigation.

The PE staff on duty in the gymnasium at the time of the assault on Mr North, whilst preventing an escalation of any disorder and properly managing Mr North's welfare, appear to have done very little to secure and preserve any evidence or identify the persons responsible. In addition, neither the Duty Governor, nor the Orderly Officer appears to have taken command of the incident beyond segregating Mr North, despite its severity and the potential for repercussions.

Every indication suggests that Mr North was rightly segregated on 22nd July 2008 under Rule 45 for reasons of his own protection. The Prison Service Order (PSO 1700) which outlines the policy and procedure in relation to segregation was correctly applied throughout the whole period from initial sign-on until his transfer to C wing on 6th September 2008.

During his segregation, Mr North was seen daily by various Governors. He was in touch with his legal representatives, both by letter and by telephone, asking them to make representations to the prison authorities to return him to his wing. He saw the Independent Monitoring Board on their regular visits to the Segregation wing and his situation was reviewed every fortnight as required by Prison Service Orders. Throughout his period of segregation, Mr North continually challenged the decision and indeed the necessity to keep him segregated for his own protection. He stated to staff and managers at Whitemoor that he was not at risk of further assaults from other prisoners at the establishment. He also sought the assistance of his solicitors, Legal Practice 1, to try and secure a return to normal location. This included Mr North sending them a handwritten note stating that he had not been assaulted in the gymnasium but had suffered an accident. In his first interview with the lead

investigator, Mr North agreed that these actions were less than honest. Subsequently, via his current solicitor, Mr North stated that he did so because his main aim was to get out of segregation. Acknowledging that he had been assaulted would, in his opinion, have justified his ongoing segregation.

Mr North was told that staff were trying to negotiate a transfer to another prison for him but that he would be staying in the Segregation Unit for the foreseeable future. On 27th August, Mr North's solicitors sent a letter before claim to the National Offender Management Service (NOMS) relating to Mr North's continued segregation. The letter gave NOMS until August 29th to return Mr North to normal location.

On 27th August 2008 a decision was made to return Mr North to normal location, that is back to a wing. Before the move could be made, further intelligence came to light which suggested Mr North may be at risk. The decision was then reversed and Mr North remained in segregation. On 29th August, a letter was written to Mr North's solicitors explaining the reasons for the reversal of the decision and stating that Mr North was "*unlikely to be returned to normal location at Whitemoor*".

On 3rd September Mr North was told that he would not be returning to a wing at Whitemoor but on the same day both HMP Wakefield and HMP Full Sutton rejected Whitemoor's request to accept Mr North on transfer. Mr North was still being told that he would be transferred as soon as possible and letters continued to be exchanged between Mr North and his solicitors and between his solicitors and the prison. The solicitors made it clear that Mr North wanted to return to normal location and that they

viewed the decision for him to remain segregated as flawed. They required the prison to return Mr North to normal location by 9th September.

On 5th September the decision was taken to return Mr North to normal location. The decision was communicated to Mr North later that same day and he was reported to be in a good mood. He was moved back to a wing on 6th September, however he was moved not to A wing but to C wing where he had previously said that there were prisoners with whom he could not associate. Mr North said that he protested about being moved to C wing but he remained unable to be specific about the member of staff to whom he complained. Staff who dealt with Mr North during his transfer from Segregation to the wing said that he made no complaint about going to C wing.

Prior to Mr North's return to C wing, there was very little intelligence held by Whitemoor to suggest that he was at risk. Most of the intelligence held related to the previous assault on 22nd July in the gymnasium. The intelligence that did exist was prisoner-generated, non-specific and uncorroborated. The intelligence did not provide any indication as to why, from whom or from where there was any threat to Mr North. The only indicator referred to his ongoing dispute with Muslim prisoners. Mr North did not appear, based upon what was known and recorded, to be at any greater risk than was faced by most other prisoners at Whitemoor.

Mr North arrived on the wing during morning Association and was located in a cell on the ground floor of Green Spur. He was not locked in the cell but left to settle in to his surroundings and have his lunch. He was then escorted to A wing over the lunchtime lockup period to pack and collect the kit he had left there when he was first segregated in July. He was then returned to C wing at about 14.00 hours. C wing was on Association, that is all the prisoners were unlocked and moving about freely on their spurs. Mr North was escorted to his cell and left to unpack his belongings. His door was left unlocked since there were no restrictions on him.

Had Mr North chosen to cooperate with prison staff and assist with the identification of his suspected assailants from 22nd July, he would almost certainly not have been moved to C wing, Green Spur on Saturday 6th September. Prisoner 1 was now located in a cell two doors along the landing from where Mr North was located. Prisoner 1 was one of the two individuals subsequently segregated on suspicion of being involved in the second attack on Mr North on 6th September.

At approximately 14.20 hours Officer 10 visited Mr North cell to discuss with him the provision of a television. He found Mr North sitting on his bed, bleeding from head wounds and in a dazed state. He immediately summoned help from colleagues who were close at hand but the alarm bell was not sounded. Mr North was removed from the cell to a secure, prisoner-free area of the wing and his cell was locked. The Control Room was alerted to the situation, the Orderly Officer attended the scene and the Duty Governor may have been on the wing at the time although he has no memory of that. Records confirm that he had visited the wing around the time of the attack on Mr North.

Following the discovery of Mr North, he informed Officers that he had sustained the injuries as a result of a fall. Officers knew this not to be the case and concluded immediately that he had been badly assaulted. Over the next 24 hours, Mr North continued to give varying accounts as to when, where and how he had sustained his injuries.

Mr North was taken to the Healthcare Centre at Whitemoor where his injuries were assessed and an ambulance was called. He was taken to Hospital 1, under escort, for treatment and then released back to HMP Whitemoor later that evening. On the return journey, he was seen and heard banging his head against the cell wall inside the escort vehicle. He also vomited. The escort staff asked Mr North to stop banging his head and he complied. On return, he was located in the Healthcare Centre for the night under close observation. The information that he had been banging his head and had vomited during the return journey was reported to the Orderly Officer, Principal Officer 4.

Virtually every member of staff interviewed as part of this investigation expressed their surprise that C wing, or as an absolute minimum, Green Spur, was not immediately locked up after the assault on Mr North was discovered on 6th September. In fact, the wing routine was allowed to continue as normal and prisoners were allowed to leave the wing to attend the gymnasium. There would appear to be little doubt that this contributed to the ability of prisoners to destroy or conceal any evidence that may have been available to support both internal and criminal investigations.

The immediate concern after the discovery of Mr North seems to have been both to deal appropriately with Mr North's injuries and to prevent his escape from custody. The Police were informed that Mr North was to leave the prison en route for hospital but that was because of his security status and the need for Police support. The severity of his injuries appears not to have been understood by prison staff and, as a result, the matter was not reported to the Police as a potential serious crime. The more senior of the two Governors on duty that day, Governor 5, was not made aware of the injuries to Mr North when he was discovered and she found out about the incident almost by accident when she became aware of the ambulance arriving to take him to hospital. From there on, she seems to have taken command of the situation but by then, the evidence was lost, the prisoners were moving around the prison and she was trying hard to make up lost ground.

The investigation did not identify any established procedure at Whitemoor whereby the Police were notified of serious crimes taking place within the establishment, particularly out of hours and at weekends. Staff were unclear as to who in the prison was responsible for that decision and for taking action. The accepted process seemed to be to alert the Police Liaison Officer; however, there had been a recent change of personnel in that role and the new incumbent did not operate a 24-hour on call system as his predecessor had done. The prison should have alerted the Police Control Room to the serious injury and possible serious crime. Instead, they confined their contact to one of asking for support for the hospital escort.

In addition, there appeared to be little recognition by many of the staff of the requirement to act promptly in order to secure and preserve evidence, and the need

for early identification and management of suspects. The lead investigator found no evidence to indicate that anyone at the scene of the incident had the authority, or the initiative, to collate information and take charge. That should have been the job of the Orderly Officer with the Duty Governor overseeing matters and keeping the more senior Governor informed. That process was lacking. The contemporaneous notes made by Governor 5 indicate that she was aware of the shortcomings. She planned that the following day, 7th September, C wing would remain locked up to allow searching and gathering of information and intelligence to take place.

During the early hours of 7th September, there was a deterioration in Mr North's condition and after consultation with the out of hours Doctor, SuffDOC, he was taken to Hospital 1. He could not be admitted there and was eventually taken to Hospital 2 where he remained until his transfer back to Whitemoor on 3rd October 2008.

On Sunday 7th September C wing remained locked up and evidence-gathering took place alongside some searching of communal areas on the wing. Information began to emerge concerning the severity of Mr North's injuries which were thought at one point to be life-threatening. Information suggested that there were two suspects for the attack on Mr North, Prisoner 1 and Prisoner 2. They had emerged as suspects almost immediately after the attack on Mr North on Saturday afternoon. An officer who noticed some unusual activity involving these two men stated that he passed that information very quickly to the Duty Governor, Governor 2. Governor 2 had no recollection of this and any action that could and should have been taken at that point was not pursued.

All of the available evidence suggests that it was Police Inspector 1, duty officer in Cambridgeshire Police Control Room on the morning of Sunday 7th September 2008, who first recognised the need for a criminal investigation into how Mr North received his injuries. He contacted PC 2 who had been the Police Liaison Officer at the prison, asking for more information about the incident. Staff at Whitemoor should have taken steps to secure a Police investigation into this matter much earlier. It cannot be judged with any degree of certainty what, if any, impact this delay had on the Police investigation that followed. The prison appeared to be too reliant on using the Police Liaison Officer at the prison as the sole mechanism for reporting the incident to the Police. In his absence, a conventional call to the Police Control Room would have been appropriate.

PC 2 rang the prison for information on the incident and then he liaised with Police Inspector 1. He then rang the Senior Investigating Officer for the weekend, Detective Chief Inspector 1, who then took command of the incident from a Police point of view.

Detective Chief Inspector 1 visited the prison at 16.30 on 7th September and met with Governor 5. He was assured of full co-operation with the prison and they discussed information gathered so far. Detective Chief Inspector 1 asked that the two suspects be segregated immediately and that was achieved by 17.43 hours. Detective Chief Inspector 1 then made a policy decision that the footwear of all prisoners on Green Spur should be seized. This was based on the fact that there was a visible outline of a footprint in the blood in Mr North's cell.

On Monday 8th September the prison remained locked up to allow extra staff to be available to seize all footwear on C wing. On Tuesday 8th September, there was a search of the cells formally occupied by the two suspects and a handover of all property seized to the Police.

Over the next few days, there was close dialogue between the Police and the prison. Both suspects, Prisoner 1 and Prisoner 2, were interviewed by the Police under caution but neither spoke in response to the questions. There was evidence to link one of the suspects to the assault on Mr North but, although that evidence was presented to the Crown Prosecution Service on three occasions, it was judged not to meet the sufficiency of evidence test. No charges were brought against either suspect.

Between 3rd July and 6th September 2008 Mr North had a number of opportunities to provide staff at Whitemoor with information that would have assisted them with the management of any ongoing risks to his welfare. He continually refused to do so and on some occasions actually lied about what had happened or what he knew. He did not, and does not, accept that he had any obligation to assist staff who were charged to manage his safety.

The Prison Service failed to conduct any form of investigation into the circumstances of either of the assaults, both resulting in serious injury to Mr North. Although it cannot be judged with any degree of certainty, it is however certainly possible that had the assault in the gymnasium on 22nd July been properly managed and investigated, the subsequent attack on 6th September may never have taken place.

On 18th November Mr North was admitted to Hospital 3. He remained there until 2nd December 2008 when he was returned to Whitemoor where he remained for a short time in the Healthcare Centre. On 17th December 2008 he was moved to the Healthcare at Prison 1.

As a result of events on 6th September 2008, both the assault on C wing and the subsequent banging of his head inside the Category A van, Mr North suffered significant brain trauma. Mr North was assessed by Professor 1, Consultant in Neurological Rehabilitation at the Oxford Centre for Enablement and Professor in Neurological Rehabilitation at Hospital 4. Professor 1 saw Mr North at the request of Mr North's solicitor. Mr North has also been assessed by Dr Louis A Loizou, Consultant Neurologist and Senior Clinical Lecturer at the University of Leeds, at the

request of the lead investigator. Dr Loizou is in agreement with the views expressed by Professor 1. As a result of the brain damage suffered, Mr North has been left with an inability to control his body temperature and to regulate his fluid intake due to lack of ability to experience thirst. He has lost his sense of smell and taste. Mr North has also suffered cognitive impairment to the extent that Professor 1 does not consider him capable of mounting a legal challenge on his own behalf. Furthermore, there have been changes in personality in that he is now more docile than he has been in the past. Whilst some of the ongoing conditions that currently affect Mr North may improve with time, others will clearly remain with him for the rest of his life. He will almost certainly face significant challenges in later life, particularly if he needs to maintain an independent existence without the support and medical supervision that he currently receives within the prison environment. It is concluded that Mr North is currently subject to an overall five-year reduction in life expectancy. There is likely to be a risk of post-traumatic epilepsy for the rest of Mr North's life.

Mr North remains in the Healthcare Centre at Prison 1 because of his need for assistance as described above. Dr Loizou considers that this environment is adequately meeting all ongoing medical requirements.

Since the time of his entry to the prison system on remand for the current offences, Mr North has been a Category A prisoner. His security category was reviewed on 9th July 2008 when it was considered that he should demonstrate a period of stability on normal location and exhibit positive custodial behaviour. Reference was made to his need to engage with his sentence plan and that in the meantime he should remain Category A. At the time of the review, it was considered that a downgrading of security

category could not be justified until there was sufficient evidence of a significant reduction in his risk of reoffending in a similar way. His next review was scheduled to take place five years from the date of the last review, that is sometime in 2013. The lead investigator has now been notified by Mr North's legal adviser that his security category was further reviewed on 21st January 2014. At that time the Secretary of State took a decision to retain Mr North's Category A status. It is believed that this decision is the subject of an ongoing Judicial Review.

A significant period of time elapsed between the two assaults on Mr North at Whitemoor in July and September 2008 and the decision by the Ministry of Justice in February 2010 to proceed with an Article 2 compliant investigation. It cannot be judged with any degree of certainty what impact the passage of time had on the quality and outcomes of this investigation. However, it is clear that the passage of time has adversely affected the ability of those interviewed to recall with accuracy and certainty the events under investigation. It may be that it has also contributed to the fact that the prison has been unable to provide the lead investigator with a number of key documents that were important to the investigation.

However, the standard of record-keeping and record management at HMP Whitemoor appears to have been somewhat inadequate in 2008. In addition to the prison's inability to provide certain documents, a number of official records were not completed at all, were incomplete or lacked detail.

During the course of the investigation and as a result of the disclosure of those documents that were relevant to the investigation, Mr North's solicitor wrote to the lead investigator on 25th February 2013 raising a number of issues. In particular, she questioned the authenticity of the handwritten record of Governor 4's decision to return Mr North to normal location on 6th September 2008. Given the nature of the allegation and in accordance with the Terms of Reference for the Article 2 investigation, the lead investigator raised the matter on the 2nd April 2013 with the Acting Head of the Offender Safety, Rights and Responsibilities Group at the National Offender Management Service, inviting them to consider conducting an independent investigation into the authenticity of the original document.

An investigation took place in January 2014 led by Governor 11. He concluded that he could find no reason to doubt the authenticity of the document and that it appeared to be a copy of the contemporaneous note written at the stated time.

As a consequence of the Article 2 investigation into the case of Mr North, the lead investigator has concluded that there should be a public hearing at which certain issues relating to Mr North's care and management whilst at HMP Whitemoor in 2008 might be further examined.

In reaching this view, the lead investigator has considered two distinct issues. The first is whether there is a serious conflict in the evidence which needs to be tested and clarified in a public hearing. The second is whether the investigation has uncovered convincing evidence of widespread or systemic failures which require a public hearing in order to maintain public confidence.

KEY FINDINGS

1. In 2008 HMP Whitemoor faced significant challenges arising from an increase in both the Muslim prisoner population and gang-related violence. Whilst work was ongoing to address these challenges, it is clear that at the time of both assaults on Mr North these issues continued to present difficulties for both staff and prisoners.
2. Mr North has a long history of violent offending. This has resulted in him spending significant periods of his life within the prison environment for a variety of offences ranging from common assault to murder. He is not a man who has only been exposed to violent offending since being sent to prison. At his most recent sentencing the Judge described Mr North's record as one of "*appalling, gratuitous and indiscriminate violence*".
3. Until the incident on 6th September 2008 Mr North had been perceived as a problematic prisoner. In order to assist with managing his behaviour and impact, he has been moved around the High Security Prisons on a regular basis.
4. During his period of imprisonment Mr North has accumulated 42 proven adjudications for breaching a variety of Prison Rules. His offending includes assaults, possession of weapons and possession of drugs. He has presented prison staff with significant challenges.

5. A significant period of time elapsed between the two assaults on Mr North at HMP Whitemoor in July and September 2008, and the decision by the Ministry of Justice in February 2010 to proceed with an Article 2 compliant investigation. It cannot be judged with any degree of certainty what impact this passage of time had on the quality and outcomes of this investigation.

6. Immediately following the attack in the gymnasium on the 22nd July 2008, Mr North clearly had an opportunity, had he wished to do so, to identify his attackers to the Physical Education Officers. It can be argued that Mr North could, and indeed should, have done more himself to assist prison staff in managing the ongoing risk to his welfare. Mr North made the task of those charged with managing any ongoing risk even more challenging by initially informing them that he had suffered an accident, and then refusing to support an internal investigation.

7. The PE staff on duty in the gymnasium at the time of the assault on Mr North, whilst preventing an escalation of any disorder, and properly managing Mr North's welfare, appear to have done very little to secure and preserve any evidence or identify the persons responsible. In addition, neither the Duty Governor nor the Orderly Officer appears to have taken command of the incident, beyond segregating Mr North, despite its severity and the potential for repercussions. There was no internal investigation conducted in accordance with PSO 1300 and the assault was not reported to the Police, as per national guidance, for criminal investigation.

8. Throughout his period of segregation Mr North continually challenged the decision, and indeed the necessity, to keep him segregated for his own protection. He continually stated to staff and managers at HMP Whitemoor that he was not at risk of further assaults from other prisoners at the establishment. He also sought the assistance of his (then) solicitors, Legal Practice 1, in order to try and secure a return to main location. This included Mr North sending them a handwritten note stating that he had not been assaulted in the gymnasium but had suffered an accident. In his second interview with the lead investigator Mr North agreed that these actions were less than helpful. Subsequently, via his current solicitor, Mr North states that he did so because his main concern was to get out of Segregation. Acknowledging that he had been assaulted would, in his opinion, have justified his ongoing segregation.

9. Between the 3rd July 2008 and 6th September 2008 Mr North had a number of opportunities to provide staff at HMP Whitemoor with information that would have assisted them with the management of any ongoing risks to his welfare. He continually refused to do so and on some occasions actually lied about either what had happened or what he knew. He did not, and does not, accept that he had any obligation to assist staff who were charged with managing his safety.

10. Every indication suggests that Mr North was rightly segregated on the 22nd July 2008 under Rule 45 for reasons of his own protection. PSO 1700 which outlines the policy and procedure in relation to segregation was correctly applied throughout the whole period from initial sign-on through until his transfer to C wing on the 6th September 2008.
11. Due to the unavailability of documents from HMP Whitemoor, it cannot be judged if all reasonable steps were taken by Population Management to relocate Mr North to another High Security Prison during his period of segregation in August and September 2008. The investigation would have expected to find additional documents to support any further enquiries with other prisons had they taken place.
12. Prior to Mr North being returned to C wing from the Segregation Unit on the 6th September 2008, there was very little intelligence held by HMP Whitemoor to suggest that he was at risk. Most of the intelligence held related to the previous assault on the 22nd July 2008 in the gymnasium. The intelligence that did exist, was prisoner-generated, with the inherent risks regarding motivation and manipulation. Furthermore, it was non-specific and uncorroborated. The intelligence did not provide any indication as to why, from whom, or from where there was any threat to Mr North. The only indicator referred to his ongoing dispute with Muslim prisoners. Mr North did not appear, based upon what was known and recorded, to be at significantly greater risk than that faced by numerous other prisoners at Whitemoor. It is somewhat surprising that Governor 4 appears to have failed to fully consider the significance of the gym incident on

the 22nd July 2008 when carrying out his risk assessment, especially given that this had been the trigger for Mr North's segregation. That said, the intelligence and evidence available to the lead investigator indicates that, on the balance of probabilities, it was the right decision to return Mr North to C wing on the 6th September 2008. Governor 4 did not have the benefit of hindsight.

13. Had Mr North chosen to cooperate with prison staff and assist with the identification of his suspected assailants from the 22nd July 2008, he would almost certainly not have been moved to C wing, Green Spur, on Saturday 6th September 2008. One of them, Prisoner 1, was now located in a cell two doors along on the same landing from where Mr North was located on Saturday the 6th September 2008. Prisoner 1 was one of two individuals subsequently segregated on suspicion of being involved in the second attack on Mr North on Saturday 6th September 2008.

14. HMP Whitemoor failed to conduct any form of investigation into the circumstances of either of the assaults, both resulting in serious injury to Mr North. In addition, on both occasions, they also failed to preserve the scenes for timely forensic examination or report the incidents to the Police for criminal investigation. The lead investigator sees this as a significant failing by staff at HMP Whitemoor. Although it cannot be judged with any degree of certainty, it is however certainly possible that had the assault in the gymnasium on the 22nd July 2008 been properly managed and investigated, the subsequent attack on the 6th September 2008 may never have taken place.

15. Following the discovery of Mr North in his cell, with significant visible injuries, on the afternoon of Saturday 6th September 2008, he immediately informed the Officers on duty on the wing that he had sustained the injuries as a result of a fall. Officers knew this not to be the case and concluded immediately that he had been badly assaulted. He then continued to give varying accounts as to when, where and how he had sustained his injuries. This may well be attributable to the, now diagnosed, brain trauma.

16. There did not appear to be an established procedure at HMP Whitemoor whereby the Police were notified of serious crimes taking place within the establishment. Staff were unclear as to who in the prison was responsible for that decision and taking action. In addition, there appeared little recognition by many staff of the requirement to act promptly in order to secure and preserve evidence, and the need for early identification and management of suspects.

17. In the opinion of the lead investigator, two key questions remain unanswered. First and foremost, who on the afternoon of Saturday 6th September 2008 was actually in command of HMP Whitemoor? Secondly, who was responsible for taking command of the aforementioned incident that afternoon? This was a serious assault, and should have been recognised and managed as such, from the very outset. Unfortunately, that appears not to have been the case.

18. All of the available evidence suggests that it was Police Inspector 1, duty officer in Cambridgeshire Police Control Room, who first recognised the need for a criminal investigation into how Mr North received his injuries. This didn't happen until very late morning on Sunday 7th September 2008. The reality is that staff at HMP Whitemoor should have taken steps to secure a Police investigation into this matter much earlier. It cannot be judged with any degree of certainty what, if any, impact this delay had on the Police investigation that followed. The prison appeared to be over-reliant on using the Police Intelligence Officer at the prison as the sole mechanism for reporting the incident to the Police. In his absence a conventional call to the force Control Room would have been appropriate.

19. Virtually every member of prison staff interviewed as part of this investigation, regardless of grade, expressed their surprise that the wing (C wing), or as an absolute minimum Green Spur, was not the subject of an immediate lockdown after the assault on Mr North on the 6th September 2008. This course of action would have assisted greatly with the tasks of identifying offenders and securing any available evidence. There would appear little doubt that this contributed to the ability of prisoners to destroy or conceal any evidence that may have been available to support both criminal and internal investigations.

20. As a result of events of the 6th September 2008, both the assault on C wing and the subsequent banging of his head inside the Cat A transport van, Mr North suffered significant brain trauma. Medical evidence suggests that whilst some of his ongoing conditions may improve with time, others will clearly remain with him for life. He will almost certainly face significant challenges in later life, particularly if he needs to maintain an independent existence without the support and medical supervision that he currently receives within the prison environment. It is concluded that Mr North is currently subject to an overall five-year reduction in life expectancy.
21. Whilst this investigation has identified some shortcomings in relation to a variety of systems and processes that were in place at HMP Whitemoor in 2008, all of the evidence indicates that Mr North received a high standard of medical care and attention whilst at the prison. This relates to staff present in the gymnasium and on C wing at the time of the two assaults through to medical staff in the Healthcare Centre.

LIST OF RECOMMENDATIONS

1. If it has not already done so, HMP Whitemoor may wish to consider the benefits to be obtained from reviewing internal procedures and guidance for the management, recording and investigation under PSOs 1300, 2700 and 2750 of both prisoner on prisoner assaults and unexplained injuries. It may also be considered appropriate to reinforce any guidance with staff at the establishment in order to ensure an appropriate level of compliance.
2. If they have not already done so, NOMS and HMP Whitemoor should consider if current procedures and staff training provide for the full and accurate completion of official prison documents. Adequate audit and storage arrangements should also be considered as part of any subsequent review. The investigation highlighted a high number of either incomplete, or missing, official prison records. HMP Whitemoor should consider the policy on retaining both draft and final copies of letters and ensure that a process is in place to readily differentiate between draft and final versions of documents.
3. If it has not already done so, NOMS should consider the requirement, and benefits to be gained, by reviewing how it responds to managing serious prisoner on prisoner assaults or indeed other critical incidents. Whilst not necessarily exclusive, this review should consider including issues such as command structure, scene and evidence preservation, offender identification and management, plus timely investigations and referral to the Police. There should

be absolute clarity at any given time as to who is in command of the prison should a critical incident arise.

4. If it has not already done so, NOMS should consider the requirement to review, at both national and local levels, protocols and procedures for referring crimes that take place within prisons to the Police, so that all organisations are clear around what is expected of them and the service that will be provided in return.
5. If it has not already done so, NOMS should consider reviewing PSO 1700 relating to segregation. Any such review should consider including policy, procedural guidance and a risk assessment matrix for the occasions when prisoners return to main wings from Segregation outside of the main Segregation Review Board process.
6. If it has not already done so, NOMS may wish to consider reviewing its policies and procedures relating to the seizure, recording, retention and continuity of seized items, particularly in respect of critical incidents or where items are likely to be used as evidence in subsequent criminal proceedings.
7. NOMS may wish to consider whether the introduction and use of bespoke bound notebooks would be appropriate for use by personnel engaged in the management of serious or critical incidents. Similar documents are in use in other organisations for the purpose of recording, in one place, notes, thought processes and subsequent decisions.

8. If it has not already done so, staff at HMP Whitemoor may wish to consider reviewing local procedures for the early notification of significant incidents or events to the Independent Monitoring Board.
9. Independent Monitoring Boards across NOMS may wish to consider the merits or otherwise of visiting prisoners whilst they are temporarily resident in external settings such as hospitals. This could be particularly relevant if a prisoner is absent from the prison for a protracted period of time.
10. If it has not already done so, HMP Whitemoor may wish to consider reviewing current arrangements in relation to prisoners' access to razor blades. The prison should be satisfied that any arrangements for access also provides for an appropriate level of protection from harm for both staff and other prisoners.

CHAPTER 1.

INVESTIGATION, COMMISSION AND TERMS OF REFERENCE

1.1 The Commission to conduct an Article 2 European Convention on Human Rights (ECHR) investigation into the case of Mr North was formally issued on the 27th April 2010 by the Head of Safer Custody and Offender Policy Group, acting on behalf of the Secretary of State for Justice. Safer Custody and Offender Policy Group (SCOP) formed part of the National Offender Management Service (NOMS), an executive agency of the Ministry of Justice. The investigation was commissioned in order that the State could discharge its obligations under Article 2 (ECHR) to investigate the circumstances surrounding a serious assault on Mr North on the 6th September 2008 at HMP Whitemoor. During the period of the investigation the Safer Custody and Offender Policy Group was superseded by the Offender Safety, Rights and Responsibilities Group (OSRRG), which was itself superseded in May 2013 by the Equality, Rights and Decency Group.

1.2 The Terms of Reference for the investigation were as follows:-

- *to examine the management of Mr North by HMP Whitemoor from the date of reception on the 3rd July 2008 until the date of the incident on the 6th September 2008 and any relevant intelligence, and in particular, to consider the decision*

to move Mr North from the segregation unit to C Wing on the 6th September 2008;

- *to examine the steps taken by HMP Whitemoor following the incident on the 6th September 2008 in light of current prison policies and procedures;*
- *to consider, within the operational context of the prison service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;*
- *to provide a draft and final report of [your] findings including the relevant supporting documents as annexes;*
- *to provide [your] views, as part of [your] draft report on what [you] consider to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State for Justice will take into account and consider any recommendations made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under ECHR.*

1.3 The following guidance was also issued in support of the Terms of Reference:-

Procedures

- *This is an Article 2 investigation and must be conducted in an open, transparent and even-handed manner*
- *Any documents disclosed [to the lead investigator] by the Secretary of State for Justice will be subject to a confidentiality undertaking and redaction where necessary, for example for security reasons or to comply with the Data Protection Act 1998*
- *It will be for [the lead investigator] to determine which documents are relevant to the investigation and which documents will be attached as an annex to the draft report. All documents annexed to the report will be subject to redaction where necessary for the reasons set out above*
- *Subject to [the confidentiality undertaking] above, we would ask that any correspondence in respect of this investigation sent by [you] is sent to both the Secretary of State for Justice and Mr North's representatives simultaneously. We would also ask that any correspondence received by [you] from the Secretary of State for Justice or Mr North's representatives*

in respect of this investigation is forwarded to the other party if they have not been copied in.

Involvement of Mr North

[You] must give Mr North, through his representatives, the opportunity to participate in the investigation. The Secretary of State for Justice will make adequate funding available to Mr North in order to allow him to be involved in the investigation to the extent necessary to safeguard his interests.

Access to Witnesses

[You] may undertake interviews with such witnesses as [you] deem relevant for the purposes of examining the management of Mr North by HMP Whitemoor from 3rd July 2008 to the date of the assault on the 6th September 2008. [You] should identify in advance those witnesses of fact who are, or were at the relevant times, employed by the National Offender Management Service that [you] intend to interview, so that they can be offered support and representation if necessary. Those witnesses should be contacted initially through a named contact point in the relevant prison, who will act as prison liaison for this investigation. [You] are then required to provide the witnesses with a written explanation of your role, terms of reference and the purpose of the interview.

Preliminary Evidence Gathering

[You] will have access to Mr North's prison records and medical records and any other relevant documents held by the Secretary of State for Justice, including local and national policy documents, which must be obtained via [your] named contact point in Safer Custody and Offender Policy Group (SCOP).

- *If [you] form the view that a disciplinary investigation should be undertaken, [you] must alert the Secretary of State for Justice through SCOP. If at any time findings emerge from the investigation which [you] consider require immediate action, you must alert the Secretary of State for Justice to those findings through SCOP. Any investigation by the Police will take precedence over this investigation. If at any time during the investigation [you] form the view that a criminal investigation should be undertaken, you must alert the Police.*

Chronology

A chronology of events should also be prepared early in the investigation and distributed to all parties. This may be amended as the investigation progresses with the agreement of the parties.

Advance disclosure of report and advance notice of criticisms

Any identifiable individual who may be criticised in [your] report must be given advanced disclosure of the criticisms and be given the opportunity to respond before the report is finalised. This may be done by sending in confidence relevant extracts from the draft report to that individual for identification of errors or omissions and any comment.

- *[You] must then submit [your] report in draft with an Executive Summary and annexes and a list of documents considered but not annexed as not deemed to be relevant to the Secretary of State for Justice so that he may check the report for sensitive information (such as identification of vulnerable prisoners or intelligence source) that may require redaction. The Secretary of State for Justice will notify [you] of any required redactions not later than five working days after his receipt of the draft report. Thereafter [you] will send the draft report*

(subject to any redactions) in confidence to the parties to check for factual accuracy.

- *[You] will submit [your] final report with the annexes simultaneously to the parties (subject to any redactions).*

Public Scrutiny

- *The State's investigative obligation under Article 2 ECHR includes an element of public scrutiny. In most cases publication of the investigators final report will be sufficient to satisfy this obligation, but in exceptional cases a public hearing may be needed. If, for example, there are serious conflicts in the evidence, questioning witnesses in a public setting may be necessary to test the credibility of their evidence. Or, if the investigation uncovers convincing evidence of widespread or serious systemic failures, a public hearing may be warranted in order to maintain public confidence in the systems in place. Your draft report should include [your] views as to what you consider to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State for Justice will take your views into account and consider any recommendations made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 ECHR.*

Publication

Subject to necessary redaction, [your] report will be published on the Independent Advisory Panel on Deaths in Custody website.

1.4 Allegation of Internal Collusion / Corruption

1.4.1 At the very outset of the investigation Mr North's solicitor, Solicitor 2 of Legal Practice 2, raised with the investigators her concerns that the attack on her client had in some way been 'facilitated' as a consequence of some collusion or corrupt activity by staff at HMP Whitemoor. Solicitor 2 raised this issue on a number of occasions during subsequent conversations with the investigators.

1.4.2 This matter was discussed on the 31st August 2010 during an initial meeting between the lead investigator, Solicitor 2, Mr North's mother and Mr North's sister. It soon became clear that there was no actual evidence available to support the 'corruption' theory at that time. Indeed Mr North's mother advanced the view that as Mr North was a difficult prisoner and Prison Officers are only human, perhaps they just 'allowed it to happen'. She did however confirm that she had nothing tangible to support that possibility. What appeared to be informing her concerns was the

fact that Mr North had been so badly assaulted within such a very short period of time (20 - 25 minutes) after the wing had been unlocked for afternoon Association, and on his very first day of return from the Segregation Unit.

1.4.3 Whilst there was no prima facie evidence to support the theory, advanced by Solicitor 2, of any internal corruption or involvement by staff at HMP Whitemoor, the lead investigator included this issue as a central pillar of the investigation strategy. Clearly once raised, any such suggestions need to be thoroughly investigated in order to bring the issue to a satisfactory conclusion one way or the other. This is of great importance to all parties to the investigation and justice in general.

1.4.4 During the course of the investigation no evidence emerged to indicate that any staff at HMP Whitemoor were in any way involved in either of the assaults on Mr North. The team of Police investigators from Cambridgeshire Constabulary who conducted the criminal enquiry into the attacks on Mr North post the 6th September 2008 confirmed that they did not identify any issues of concern regarding any staff at the prison. Whilst that was not the primary focus of their investigation, one might reasonably have expected them to have identified any related issues if they had existed.

- 1.4.5 In addition, and in the interests of completeness, investigators conducted enquiries with the National Offender Management Service Corruption Prevention Unit in order to establish if they held any material that might be considered relevant to this investigation. The Detective Chief Inspector, Head of Unit, has formally confirmed to the lead investigator that having searched their records they do not hold any such material.
- 1.4.6 Based upon the information available to the lead investigator the only reasonable conclusion that can be drawn in relation to this issue is that there was no involvement either directly or indirectly, by any staff at HMP Whitemoor in either of the assaults on Mr North.
- 1.4.7 At a much later stage in the investigation Mr North, via his solicitor, raised a specific concern about the possible authenticity of risk assessment document that had been written in order to inform the decision to return him from the Segregation Unit to C wing on the 5th September 2008. This document had been written by the then Head of Security. In essence, the concerns raised centred on the fact that some of the language used in the document suggested that it might have been written retrospectively and not at the time indicated. At the request of the lead investigator, this matter was subsequently the subject of a

separate, internal NOMS investigation. This matter is covered in greater detail later in this report at Chapter 17.

CHAPTER 2.

HMP WHITEMOOR

2.1 HMP Whitemoor is a maximum security prison for Category A and B male prisoners. It is one of eight High Security Prisons in the Prison Estate. At the time of the incidents under investigation, there were four main residential wings containing individual cells. The establishment had an operational capacity of 458 places. The Governing Governor was Governor 1.

HMCIP Inspections

2.2 Between 7th and 11th April 2008, H.M Chief Inspector of Prisons carried out an unannounced full follow-up inspection at HMP Whitemoor. This was a follow-up to a full announced inspection of the establishment between 30th January and 3rd February 2006. As per usual practice, HM Chief Inspector produced a comprehensive report of her findings at the conclusion of the follow-up visit. The report is dated June 2008 and not only makes an assessment of current findings, it aims to monitor progress against areas identified for attention and improvement at the last inspection. This report seeks to explore some of those key areas in greater detail.

2.3 In the introduction to the report dated June 2008 HM Chief Inspector makes the following observations:

“Like the other dispersals, it was facing increased risks: more gang activity, more young men serving very long sentences and a small number of men convicted of terrorist offences. There were also other challenges. HMP Whitemoor’s black and minority ethnic population had recently expanded significantly - rising to 150, of whom 120 were Muslims - in an area, and with a staff group, which is almost exclusively white. Finally, there was evidence of a significant drug problem, particularly heroin use.

This is a challenging combination of risks. There had been some progress - use of force and segregation had reduced and was being effectively monitored; and there were well developed plans to move out the prisons vulnerable prisoner population, who were not being properly supported. However, more than half of the prisoners surveyed said that they had felt unsafe at Whitemoor: significantly more than at other high security prisons, or at Whitemoor itself at the previous inspection. This was an area that required more active management. Formal anti-bullying procedures were under-used and suspected intimidation and unexplained injuries not always fully investigated. There was evidence that the segregation unit and the inpatient unit were being used as places of safety.”

She goes on to say,

“There had undoubtedly been some improvements at Whitemoor since the previous inspection. However, at the same time, the population had become more challenging, and it was not evident that the prison had yet been able to rise to those challenges. The imminent departure of vulnerable prisoners should allow staff and managers to focus on managing the considerable and growing risks. This however, will require active management and much greater staff engagement with all prisoners. In particular, as we have said in relation to other prisons, especially high security prisons, the Prison Service as a whole needs to equip staff better to deal with the growing number of Muslim prisoners. This inspection, and others have charted a growing disaffection and distance between those prisoners and the prison system: a gap which urgently needs to be bridged.”

2.4 All HMCIP inspection reports include a summary of an establishment’s performance against the model of a healthy prison. The four criteria of a healthy prison are:

- Safety
- Respect
- Purposeful activity
- Resettlement

Under each criterion, inspectors make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against it. In some cases, this performance will be affected by matters outside the establishment's direct control, which needs to be addressed by the National Offender Management Service.

2.5 The four criteria used in order to assess performance are:

- performing well against the test
- performing reasonably well against the test
- not performing sufficiently well against the test
- performing poorly against the test

2.6 With regard to Safety at HMP Whitemoor, HM Chief Inspector made a number of observations that are relevant to this Article 2 Investigation.

- *“Use of force had reduced and the segregation unit operated reasonably well. However, many prisoners reported feeling unsafe and under threat from each other and from staff. Formal violence reduction procedures were underused.”*

2.7 The June 2008 report concludes, *“The prison was not performing sufficiently well against the healthy prison test.”*

- *“Some violence reduction initiatives had begun but many prisoners said that they felt unsafe. Responses in our survey about safety were much worse than at comparator prisons, and had also deteriorated significantly since the previous inspection. One-third of prisoners said that they felt unsafe at the time of the inspection, and more than a half said that they had felt unsafe at sometime. Structured interviews with prisoners indicated that many felt threatened, both by staff and by other prisoners, and it was apparent that officers did not manage some prisoners effectively. Formal anti-bullying procedures were underused, particularly on A and B wings, and suspected incidents of intimidation and unexplained injuries were not always well investigated. There were no specific interventions to deal with identified bullies and little support for victims.”*
- *“The Security Department was well managed and the security committee had a clear focus. Useful intelligence was received and there were efficient systems to process it, with some work to identify and deal with gang activity. However, communication of security issues with staff working on residential units was inadequate. Risk management systems were effective and a*

useful monthly intelligence report identified trends and potential problems.”

- *“Prisoners with experience of the segregation unit said that they had been well treated: indeed it was regarded as a place of safety. The unit was usually full, and some men stayed for long periods without a clear individual progression plan”.*
- *“Adjudications were mostly well conducted, but some records indicated insufficient investigation. Trends in adjudications were analysed by managers.”*

2.8 As part of the aforementioned healthy prisons assessment, inspectors made a number of recommendations the following being of particular relevance to this investigation:

“All staff should be trained in the violence reduction/anti-bullying strategy, challenge suspected bullying behaviour and gang activity, and ensure that victims are well supported.”

2.9 As part of the follow-up inspection, the Inspectorate also examined in great detail the progress made against recommendations made in the previous report (2006).

2.10 With regard to 'Duty of Care - bullying and violence reduction' the expected outcomes are defined as *"Everyone feels safe from bullying and victimisation (which includes verbal and racial abuse, theft, threats of violence and assault). Active and fair systems to prevent and respond to violence and intimidation are known to staff, prisoners and visitors, and inform all aspects of the regime."*

2.11 Highlighted below are the relevant recommendations as identified by Inspectors during their 2006 inspection and their assessment of progress made during their follow-up visit in April 2008.

- *There should be systems to raise the confidence of prisoners on A and B Wings in reporting incidents of bullying.*

Not achieved. There was no evidence to suggest that bullying was less prevalent on A and B Wings, but fewer incidents were reported on these wings. The prison had conducted its own violence reduction survey in January 2008 and, although the response rate was very low (8% of the population responded) it highlighted that prisoners had experienced bullying but lacked confidence in staff to tackle the problem. An action plan to address the findings of the violence reduction survey had been created, although the planned actions had not yet been completed. However, the proportion of prisoners in our survey who said that they had reported victimisation had increased

significantly since 2006, from 22% to 33%. Prisoners on the Fens Unit were more likely to report victimisation.

We repeat the recommendation.

- There should be specific intervention work for identified bullies on all residential units.*

Not achieved. There were no specific interventions for bullies. The intervention tools that the prison had developed for challenging bullies were staged sanctions, and not interventions that might increase the perpetrator's awareness of the impact of bullying or explore his motivation. The safer custody co-ordinator could make referrals to accredited offending behaviour causes, but this had not happened.

We repeat the recommendation.

- Unexplained injuries reported on F213 forms should be routinely referred for investigation as potential bullying incidents.*

Not achieved. Some unexplained injuries were reported on F213 forms (the form used to report injuries to prisoners); however, we found evidence of incidents of self harm also being reported on

the same type of form rather than the F213SH. All F213 and F213SH forms were sent to the Safer Custody Co-ordinator. The Safer Custody Co-ordinator said that all unexplained injuries were investigated, but there were no records kept of the outcome of the investigations or if any were found to be linked to bullying. In two cases we looked at, F213s had been submitted, but the Safer Custody Co-ordinator was not clear if they had been investigated. The expectation was that the officer who completed the form or wing staff were required to complete the investigation and then notify the Safer Custody Co-ordinator. This did not appear to happen.

We repeat the recommendation.”

2.12 In this section of the report, HM Chief Inspector of Prisons also made a number of new recommendations which included:-

- *The safer custody meeting should analyse safer custody information for patterns, and investigate and discuss the implications for the development of the violence reduction strategy.*
- *The prevalence of gangs at HMP Whitemoor should be assessed and all staff briefed about how to identify, and deal with gang behaviour as part of the violence reduction strategy.*

- *Records should be kept of investigations into unexplained injuries, and the conclusions reached reported formally at safer custody meetings.*

2.13 During the course of the 2008 inspection, the Chaplaincy team at HMP Whitemoor had raised concerns about the numbers of prisoners converting to the Muslim faith in case they were being coerced. This issue potentially becomes relevant to this investigation given that it has been suggested, on a number of occasions throughout the investigation, that Mr North had an ongoing dispute with Muslim prisoners due to his failure to convert and previous incidents of violence with members of the Muslim faith. Indeed, it has been suggested that the attacks were directly attributable to this issue.

2.14 The Chaplaincy team went on to say that they interviewed all prisoners who wished to convert to any other faith, in order to help avoid such coercion. Security staff were also informed when applications to convert were made. HM Chief Inspector made a new recommendation that the Chaplaincy should continue to monitor religious conversions.

2.15 Section 6 of the Inspector's report deals with Good Order and Discipline at the prison, and it makes the following observations that are relevant to this investigation.

- *“The security department was managed by a senior operational governor (head of operations). The day to day management of the area was the responsibility of a governor grade (head of security), supported by principal officers; senior officers; a large group of officers, including four designated intelligence collators, who were based in a separate intelligence unit, and a full time police intelligence officer.*
- *The security committee monthly meetings were well attended by appropriate representatives from relevant areas, including police liaison officers. Meetings were chaired by the head of operations. The standing agenda was comprehensive and included security reports from all residential areas, a review of incidents and an analysis of security information reports (SIRs).*
- *Security objectives were agreed through the appropriate consideration of intelligence, and progress was monitored and recorded.*
- *An intelligence unit, staffed by four full time officers, processed a large number of SIRs (an average of 500 each month) and*

published monthly intelligence assessments, which included an analysis of received information that resulted in an identification of emerging issues or trends. Action based on these findings was recommended, and then validated, during the security committee meetings.

- *Work was being carried out to identify and deal with gangs, radicalisation and possible terrorist activity. Strong links had been established with local and regional police forces and the flow of communication through the police intelligence officer was good. Monthly reports about the behaviour and activity of suspected gang members and identified terrorists were presented to the security committee. Formal plans to deal with identified or suspected issues were raised (problem profiles) and prescribed action was monitored by the security committee. A separate extremist committee had been set up alongside the security committee to advise on action concerning possible gang, terrorist or extremist activity. Despite these strong central systems, residential staff were mostly unaware of these initiatives. They expressed a fear of what they saw as a rising problem of prisoner radicalisation, and an increase in Muslim conversion. Communication between the security department and frontline officers did not appear to be effective in ensuring that all staff were involved in the prisons overall security strategy.”*

2.16 In this section of the report HM Chief Inspector made one new recommendation in relation to 'Good Order':

- *"The security department should improve communication on residential units to ensure that staffs are aware of, and involved with, important security initiatives."*

2.17 In relation to 'Discipline', HM Chief Inspector noted that during the Inspection (April 2008) they spoke to the majority of the 20 prisoners who were located on the Segregation Unit and on E wing (which was used as an overflow for the Segregation Unit). At that time they received no complaints from prisoners about their treatment. They identified that the average time spent by prisoners in the Segregation Unit was 15 days; however, they spoke to one prisoner who had been there for six months, *"and plans for his progression were unclear"*.

2.18 As part of the follow-up inspection, HM Chief Inspector conducted structured safety interviews with twenty one prisoners. These were located on a mixture of all of the residential units within the prison. This sample of twenty one prisoners consisted of a cross section of individuals with a variety of ages, length of sentence, ethnic background, religious faith, sexual orientation and disability. Highlighted below are some of the comments passed by prisoners during the course of the interviews. These are included in order to help paint a picture of prisoners' experiences and perceptions at that time. It should be noted

that this was some two months prior to the assault in the gymnasium on Mr North, and some five months prior to the attack in his cell on C wing.

- *“On the main wings it’s Muslims vs Whites. Staff are worried as what they will do when it all goes mainstream. They are beginning to outnumber everyone and don’t care - all this radicalisation and they’re extremely violent slashing people.”*
- *“The new gang are the Muslims. The Muslim group is a big group and others are looking for protection. Those who are isolated are looking for protection and so are the one’s converting as they won’t get help from screws.”*
- *“I’m in a gang and you see a rival gang member and it can be dangerous. Even if you’re not in a gang, if your mates are, it can be tit for tat.”*
- *“Prisoners break up fights not staff, so I could be stabbed because they wait if it is serious. They look after themselves.”*

2.19 As part of these interviews, prisoners were asked to give an overall rating for safety at HMP Whitemoor with 1 being very bad and 5 being very good. The average rating was 2.5. Interviewees identified the Segregation Unit, gym, showers and prisoners’ own cells as being locations where they felt vulnerable to attack. Some prisoners raised

concerns about the lack of CCTV cameras at key locations, particularly on the wings. A few prisoners raised the need for personal locks on doors to stop other prisoners from entering their cells uninvited.

2.20 As a consequence of the follow-up inspection in April 2008, the management team at HMP Whitemoor developed a comprehensive Action Plan aimed at implementing the significant number of recommendations that had been identified by the HM Chief Inspector. Many of the recommendations related to issues that were not directly connected to the points under scrutiny as part of this investigation. A copy of this 'Action Plan' has been made available to the lead investigator. It is not the intention of Investigators to comment on the progress in respect of any of the individual actions. It is clear that staff at HMP Whitemoor had accepted, and were working towards implementation of the Inspectorate's recommendations.

Whitemoor population

2.21 During the course of an interview with the lead investigator, Governor 1, the Governing Governor at HMP Whitemoor in 2008, discussed the HMCIP report in some detail. He described the prison at that time as being a complex and difficult establishment. In 2008 it had both a Dangerous & Severe Personality Disorder Unit and a Close Supervision Centre for particularly challenging 'High Risk' prisoners. At around the same time, HMP Whitemoor also held a significantly higher number of recognised gang members when compared to the other dispersal prisons and had also experienced a large increase in black ethnic minority (mainly Muslim) prisoners, the latter having increased by around 50 per cent in a relatively short period of time. This was described as having a big impact on prison life, quite often creating tensions with non-Muslim prisoners. In many cases religion was considered to be cloaking criminality.

2.22 In an attempt to address some of the aforementioned challenges, a number of strategic decisions were taken in order to improve the prison's ability to better manage the prisoners located there. One of these was that the Vulnerable Prisoner Unit was moved away from Whitemoor in order to provide additional mainstream capacity. This was focused primarily towards tackling the emerging gang culture and making the prison safer for prisoners. In essence, C wing at the prison became a mainstream residential wing. Governor 1 describes these as not being

perfect measures but the best that could be achieved within the resources available at that time. He considered that when the follow-up Inspection was carried out in 2008 it was not the best time for the prison as he considered that they were “*still in a state of flux*” and not fully through the restructuring process.

Whitemoor management structure and culture

2.23 As a consequence of some of the issues raised during interviews by staff at HMP Whitemoor, the lead investigator examined the management structure and culture at the prison during 2008. This was primarily done in order to try and establish if such issues had any impact upon the management and treatment of Mr North during his period of residence from July – September 2008, the period covered by the Terms of Reference for this investigation.

2.24 Governor 1 stated that during the period around May through until July-time of 2008 he made significant internal changes to his Management Team. He made it clear that this was an attempt to put individuals into posts that better suited their skills and experience and in order to manage what he described as “*some very weak characters*” in the team. He stated that the moves were not to everyone’s liking but it was something that had to be done to better meet the needs of the prison and everything that was going on at that time. He conceded that it was a somewhat difficult exercise given all of the emerging operational

challenges at that time. Other members of the Senior Management Team described it as a period of significant change, with some suggesting that some of the changes happened so quickly that there was very little opportunity for handover with either predecessor or successor. Nobody suggested that this in any way had any impact upon the efficient running of the establishment on a day to day basis. It has been established that Governor 1 was awarded the OBE in the 2009 New Year's Honours List for his contribution to the Prison Service. This award was instigated by a member of the management team, HMP Whitemoor.

- 2.25 One senior manager, Governor 2, spoke in negative and forthright terms around the management style of Governor 1 and the prevailing culture at HMP Whitemoor in 2008. Governor 2 has now retired from the Prison Service. In interview with the lead investigator he described the culture as being *“very aggressive, very controlling, with Senior Managers working under a great deal of fear”*. He did describe Governor 1 as *“a bright chap who is very able in many ways, with many strengths”*. He acknowledged that he had done many good things for Whitemoor. It was his opinion that when Governor 1 made a decision, then even as a Senior Manager, *“you do not challenge him”*.

- 2.26 Governor 2 went on to state that although this culture was being driven from the top down by Governor 1, there were other people at various ranks and grades who ran the prison both formally and informally via a “*climate of fear*”. He described this group of individuals as a “*drinking cabal*”, fuelling a culture of bullying. He described what he considered to be a “*systemic and organised breakdown in professional management*”.
- 2.27 The aforementioned account provided by Governor 2 was subsequently explored in greater detail during interviews with other managers who worked as part of the prison Senior Management Team at that time. This matter is considered somewhat relevant given the suggestion that Governor 1 had personally taken the decision to return Mr North to main location from segregation on Friday 5th September 2008 and communicated that decision to managers, in quite a forthright style, at the daily team meeting that morning. Governor 2 considered this to have been an unusual, if indeed not unique, course of action. This matter is explored in greater detail later in this report.
- 2.28 During interviews, almost without exception, members of the Prison Senior Management Team described Governor 1 as having a direct and forthright style of communication. They did however see this as being quite a positive trait and not something that would be unusual in the style of other Governing Governors. It was described as almost coming with the territory. The majority of comments expressed support for Governor

1 and what he tried to deliver at HMP Whitemoor. Most stated that it was just bizarre to think that people did not feel that they could challenge, in an appropriate way, his decision-making. One Governor stated that *“he was decisive, and sometimes apparently impulsive, but he didn’t stifle opposition”*. Another individual stated *“that if he told you to do something then he would expect it to happen. The culture before he arrived was a little bit more undisciplined”*. That same individual equally did not recognise him as someone who resisted an appropriate challenge, indeed he was described as someone who actually solicited feedback. Moreover, that same person considered it bizarre to suggest that Governor 1 would not in any way involve himself in the issue regarding Mr North and his return from the Segregation Unit to main location. It was suggested that such matters were routinely discussed at the morning management meetings.

Gang culture

2.29 Earlier in this chapter reference is made to the fact that during interview Governor 1 spoke about the emergence of gang culture and Muslim influence in HMP Whitemoor in or around 2008. Elsewhere in this report it will be noted that around this time Mr North had himself been in dispute with some Muslim prisoners over a number of issues which had culminated in disputes and indeed violence or threats of violence. It would appear to be a matter of opinion as to whether the two assaults on Mr North which form part of this investigation materialised as a result

of his refusal to convert to the Muslim faith and his acts of defiance towards some Muslim prisoners.

2.30 A number of Governors and other staff at the prison also spoke to the lead investigator about gangs and the influence of Muslim prisoners. One Governor, with previous experience in the Security department at Whitemoor, stated that in 2008 the establishment had a large amount of separate gangs. These consisted of recognised street gangs, organised criminal gangs, prison-based gangs and just prison-based associations. The perception was that the '*Muslim gang*' was the biggest and most influential gang of all at that time. It was stated that the overwhelming view of prison staff was that Muslim prisoners were taking over. The reality was described as being somewhat different in that it was just a small faction within that group. The vast majority of Muslim prisoners just wanted to get through their sentence whilst being allowed to practice their faith. It was a small number of extremist prisoners who were having a disproportionate impact upon other prisoners, including other Muslims.

2.31 Almost without exception everyone spoken to by investigators stated that in their opinion the Muslim influence was actually nothing to do with religious belief. Like Governor 1, they were of the firmly-held opinion that it was just a cloak for protection and simple criminality. An Intelligence Analyst told investigators that gang culture is just part of prison life. At that time it was the “*Muslim gang*”; previously it was “*street gangs*” carrying out assaults connected to the drugs and mobile phone trades in prison.

2.32 As part of the investigation, a prisoner serving a life sentence did agree to meet with investigators. He was located on C wing at the time of the second attack on Mr North, in September 2008. He confirmed that in his opinion a considerable amount of the violence associated with the Muslim faith was actually nothing to do with it. In his opinion it was plain simple gang culture. It was all to do with being a member of the biggest gang because that way you increased your chances of better protection. In his words, if you went against one of them, then you went against hundreds of them. He considered that this was most likely what happened in the case of Mr North.

- 2.33 Staff at the prison spoke about how the volume and ferocity of attacks increased considerably as the gang culture had become more established. The ethnicity issue and an increase in the number of gang members had just made the environment more complex and toxic. People who were gang members were regularly under pressure to carry out a hit [assault] on another prisoner for a fellow gang member.
- 2.34 Research established that in 2007/08 there were about 67 different gangs operating within HMP Whitemoor. At that time, with only two residential wings, it became increasingly difficult to keep opposing factions apart. With the removal of the Vulnerable Prisoner Unit, a third wing became available. However, keeping the various factions apart remained difficult.
- 2.35 The then Director of High Security Prisons, told investigators that he personally was becoming “*very cross*” at the use of the term “*Muslim gangs*”. He stated that people join gangs in prison for exactly the same reasons as they do on the outside, namely, it stops them getting attacked, provides an alliance, and makes them part of a group that supports one another. It may even be advantageous for them in respect of sourcing drugs. He stated that all of the evidence, taking into account opinions of academics and religious leaders, is that the labels “*Muslim*” and “*gangs*” conceal far more than they reveal. It is recognised as being straightforward criminality. There are many examples where Muslim

prisoners have attacked other Muslim prisoners over issues totally unconnected to religion.

2.36 In June 2010 HM Chief Inspector of Prisons published a document “Muslim Prisoners Experiences – A Thematic Review”. During interviews with prison staff it was identified that many had concerns around conversions to Islam within both High Security Prisons and Young Offenders Institutions. They were concerned that prisoners were being approached and forced to convert and this had a direct link to the emergence of the Muslim gangs. The Inspectors found that this perception was not backed up by tangible evidence. They concluded that there was little to support the view that bullying or forcible conversions were commonplace.

2.37 Equally, during the same research no prisoners surveyed spoke of being intimidated or coerced into converting to Islam. However, a number of reasons for conversion were given, including the opportunity to obtain support and protection within a powerful group with a strong identity. This would appear to be the defining reason for most people.

2.38 All of the above appears to fully reflect the understanding and opinions of the staff at HMP Whitemoor who were interviewed as part of this investigation. They appeared to the lead investigator to have a good level of knowledge on these matters and were motivated to maintain and improve their levels of understanding in relation to such issues.

Prison regime

2.39 During the relevant parts of this report investigators have examined in greater detail the prevailing prison regime on the two occasions when Mr North was the victim of violent attacks by other prisoners. Following a search of C wing post him being seriously assaulted on the 6th September 2008, a number of homemade weapons were found by staff. In essence these consisted of razor blades melted into a plastic toothbrush, in effect a homemade knife. Such implements, it is understood, are a weapon of choice amongst prisoners and are regularly recovered by prison staff across almost the entire Prison Estate.

2.40 It came to the attention of the lead investigator that a dual system for prisoners accessing razor blades was in operation at HMP Whitemoor during 2008. It is unclear if the same or similar process is in place at other prison establishments. It was confirmed by the Security department at HMP Whitemoor that prisoners using prison-issue disposable razors could only have a replacement when their old one was surrendered, i.e. a one for one exchange system. Conversely, prisoners could visit the prison shop and, using their own money, freely purchase razor blades with no degree of oversight or monitoring. Whilst perhaps adopting a too simplistic approach, the lead investigator found this surprising, with one process appearing to be at odds with the other. Indeed, one senior manager at the establishment agreed it to be “a very

strange system". Given the ability of such implements to cause harm to others, HMP Whitemoor may, if it has not already done so, consider it appropriate to review the suitability of these arrangements.

KEY FINDING 1. In 2008 HMP Whitemoor faced significant challenges arising from an increase in both the Muslim prisoner population and gang-related violence. Whilst work was ongoing to address these challenges, it is clear that at the time of both assaults on Mr North these issues continued to present difficulties for both staff and prisoners.

RECOMMENDATION 10. If it has not already done so, HMP Whitemoor may wish to consider reviewing current arrangements in relation to prisoners' access to razor blades. The prison should be satisfied that any arrangements for access also provides for an appropriate level of protection from harm for both staff and other prisoners.

CHAPTER 3.

PROFILE OF MR NORTH

- 3.1 Mr North was born in 1974. He was first convicted in 1988 at the age of 14 for burglary, and theft for which he was sentenced to two months in a Young Offender Institution (YOI). His offending continued with further convictions in 1989, 1990, 1991 and 1993, increasing in severity to include Common Assault on an adult, Aggravated Burglary and Actual Bodily Harm (ABH). The periods spent in custody became longer, and the last conviction in 1993 was for the beating of an elderly woman during a burglary. That resulted in a sentence of ten years in a YOI with a concurrent sentence of two years. Records state that 950 other offences were taken into account.
- 3.2 The convictions for which Mr North is currently serving his sentence were in December 2001 and February 2002. In 2001 he was convicted of the murder of a nightclub doorman, for which he received life imprisonment, and conspiracy to cause Grievous Bodily Harm (GBH) with intent, for which he received 12 years imprisonment concurrently. Since conviction, Mr North has stated that he admits responsibility for the murder but did not mean to kill the victim.

3.3 He had also been involved in a series of violent Post Office and Building Society raids and in 2002 he received a further six life sentences for Conspiracy to Rob x 2, Aggravated Burglary x 3 and False Imprisonment. He also received two concurrent sentences of four years each for Attempted Robbery and Wounding with Intent and a further one-year sentence for Criminal Damage. Since Mr North was by now over the age of 21, all these sentences were to be served in an adult prison. Mr North committed these offences with two accomplices, both of whom received sentences of five years imprisonment. The Judge described Mr North's record as one of "*appalling, gratuitous and indiscriminate violence*". His tariff for the life sentences, that is the time he could expect to serve before he would be eligible for release on life licence, was set at 18 years, 1 month and 20 days. That time expires on the 9th January 2020.

3.4 Whilst awaiting sentence for these offences, Mr North was held on remand at HMP Wandsworth, HMP Belmarsh, HMP Woodhill and HMP High Down. From the 26th April 2001 until the 7th February 2002, he was on the Escape List. He began his sentence at HMP Whitemoor on the 11th September 2002, and between then and the date of the first attack upon him in July 2008, he had 11 moves around five prisons in the High Secure Estate. One of those moves to Belmarsh in February 2006 was to facilitate Accumulated Visits, a process where prisoners can return to their local prison for a period of one month to receive visits from their families. The rest of the moves were made because for one reason or

another, his current prison felt that Mr North would benefit from a change of establishment.

3.5 There was a period of relative stability for Mr North between 2003 and 2006. Over this period, he managed to spend two periods of approximately ten months each at HMP Long Lartin, the second period broken only by the month spent at Belmarsh on Accumulated Visits. In between these two periods, he also managed nine and ten months respectively at HMP Full Sutton and HMP Frankland, but from late 2006, his sentence was characterised by a series of four moves of between three and six months each. The final move to Whitemoor lasted for nine months, but he spent only 19 days of that period on normal location on a wing. The rest of the time was spent in segregation, in outside hospital, or in the Healthcare Centre at the prison.

3.6 During the period from his arrival in custody on remand at Wandsworth until the assault upon him in September 2008 at Whitemoor, he was the subject of 42 adjudications proved against him for a variety of offences under Prison Rules. The offences committed by Mr North ranged from three separate charges of assaulting prison staff to three charges of destroying prison property. He had 14 adjudications for being in possession of unauthorised articles, including home made weapons, five for administering or allowing the administration of controlled drugs to himself and 12 for disobeying lawful orders. He had been involved in one fight, one fire-setting and had once been found absent from a place

where he was required to be. There were also two occasions on which he was found guilty for denying access to prison staff to an area of the prison (barricade). Apart from 18 of these charges occurring in the early days of imprisonment at Belmarsh, most of the remainder were spread fairly evenly across sentence, the frequency of offences slowing towards the end of 2007 when the frequency of segregation increased. The penalty for some of the more serious charges involved Mr North being held in the Segregation Unit under cellular confinement.

3.7 Since the assault on him in September 2008, at the time this investigation commenced Mr North had been the subject of one further adjudication for being in possession of an unauthorised article.

3.8 Since the time of his entry to the prison system on remand for the current offences, Mr North has been categorised as A, which means that he is a prisoner who is considered so dangerous to the public that escape must be made impossible. Mr North's security status was reviewed on the 9th July 2008, when it was considered that he should demonstrate a period of stability on normal location and exhibit positive custodial behaviour. Reference was made to his need to engage with his sentence plan and that in the meantime he should remain Category A. At the time of the review, it was considered that a downgrading of security category could not be justified until there was sufficient evidence of a significant reduction in his risk of re-offending. His next review was expected to take place five years from the date of the last review, namely

sometime in 2013. However, the lead investigator has now been notified by Mr North's legal adviser that his security category was subsequently reviewed on 21st January 2014 when the Secretary of State for Justice retained him as Category A. At the time of writing, it is understood that this decision is the subject of Judicial Review on the grounds that the Secretary of State failed to appropriately inform himself about Mr North's disability, capacity and personality change, including by way of obtaining medical evidence and updated expert reports.

KEY FINDING 2.

Mr North has a long history of violent offending. This has resulted in him spending significant periods of his life within the prison environment for a variety of offences ranging from common assault to murder. He is not a man who has only been exposed to violent offending since being sent to prison. At his most recent sentencing the Judge described Mr North's record as one of "*appalling, gratuitous and indiscriminate violence*".

KEY FINDING 3.

Until the incident on 6th September 2008 Mr North had been perceived as a problematic prisoner. In order to assist with managing his behaviour and impact, he has been moved

around the High Security Prisons on a regular basis.

KEY FINDING 4.

During his period of imprisonment Mr North has accumulated 42 proven adjudications for breaching a variety of Prison Rules. His offending includes assaults, possession of weapons and possession of drugs. He has presented prison staff with significant challenges.

CHAPTER 4.

REQUEST FOR ARTICLE 2 COMPLIANT INDEPENDENT INVESTIGATION

4.1 From the enquiries made by the lead investigator there does not appear to have been any form of internal investigation by staff at HMP Whitemoor following either the assault on Mr North on the 22nd July 2008 in the gymnasium or the second, and more serious assault on him in his cell on C wing on the 6th September 2008. Both of those incidents are reported on in greater detail elsewhere in this report.

4.2 Consideration should also be given to a recommendation by Mr Stephen Shaw, the then Prisons and Probation Ombudsman for England and Wales, in a report published in May 2008. Mr Shaw conducted an investigation following the case at the Court of Appeal in *R (D) v Secretary of State for the Home Department (2006)*. His recommendation reads as follows:-

“Until such time as the Jurisprudence is clarified, it is recommended that the Prison Service requires all prisons to carry out investigations into attempted suicides, incidents of serious self harm and other near deaths. These should include an independent element, and engage the person who has been harmed and/or their family. This recommendation applies to more than near suicides resulting in serious injury and probably to circumstances that would not engage Article 2, but I consider that it makes good sense nonetheless.”

- 4.3 Prior to Mr North being seriously assaulted at HMP Whitemoor for the second time on 6th September 2008, he was being legally represented by Solicitor 1, Legal Practice 1, London. In the weeks prior to the assault on Mr North there had been a significant amount of correspondence between Legal Practice 1 and managers at HMP Whitemoor. In particular, this correspondence focused on the merits or otherwise of Mr North being located in the Segregation Unit at the prison for his own protection. This arrangement had been in place since the 22nd July, the day when Mr North had been the subject of an earlier assault in the prison gymnasium.
- 4.4 Legal Practice 1, on behalf of Mr North, were challenging the decision to keep him in the Segregation Unit. On Friday 5th September 2008, Legal Practice 1 faxed a letter to Governor 4, Head of Dynamic Security, at the prison informing him that unless Mr North was relocated onto the main wings of the prison by 4 pm on Tuesday 9th September they would seek to proceed with a Judicial Review hearing.
- 4.5 The events leading up to the assault on Mr North on 6th September 2008, including the legal representation provided by Legal Practice 1, are outlined in greater detail elsewhere in this report.
- 4.6 Mr North is now represented by Solicitor 2 of Legal Practice 2 who was first instructed by members of Mr North's family on 27th October 2008.

She first visited Mr North to take instructions from him on the 13th November 2008. At that time he was being cared for within the Healthcare Centre at HMP Whitemoor. As a consequence of the visit, based on conversations with clinical staff at the prison, there were clearly concerns about Mr North's capacity within the meaning of the Mental Health Act. Legal Practice 2 subsequently instructed Professor 1 to conduct a medical examination of Mr North to include an assessment of his capacity within the meaning of the Mental Capacity Act 2005. Professor 1's findings and recommendations are covered in greater detail in Chapter 16.

4.7 On the 26th May 2009, Legal Practice 2 wrote to Treasury Solicitors in an attempt to establish whether an investigation was already ongoing into the serious assault on Mr North. By this time the criminal investigation being conducted by Cambridgeshire Constabulary had been finalised, and the Crown Prosecution Service had advised that there was insufficient evidence to charge anyone in connection with the assault on the 6th September on Mr North. This included two prisoners who had been identified as suspects and were interviewed under caution by the Police.

4.8 This letter, which set out the brief circumstances surrounding the assault on Mr North on the 6th September 2008, together with some detail of events leading up to it, requested that if an internal investigation was not ongoing then one ought to be commissioned. Representations were

made that any such investigation would need to be Article 2 compliant given the severity of the injuries to Mr North with “*persisting and perhaps serious disablement*”.

4.9 For clarity and completeness, the particularly relevant sections of this letter setting out in detail the requirement to conduct an Article 2 compliant investigation, are quoted below:-

“It is our submission that, in order to discharge its obligation under Article 2 ECHR, your client is required:

- 1) to conduct an Article 2 compliant investigation into the serious assault suffered by our client whilst in HMP Whitemoor;*
- 2) to ensure that investigation is independent, prompt provides for a sufficient element of public scrutiny and involves the victim and his family.*

The requirement for an investigation

It is clearly established that where an incident resulting in life threatening injuries to any person occurs in state custody, some investigation must take place. It is our submission that, despite the assault on our client not resulting in his death, Article 2 is nevertheless engaged and an Article 2 compliant investigation is therefore required.

There is no requirement that a death actually took place for Article 2 to be engaged as the state has, in addition to an obligation not to take life without justification, an obligation to protect life. In R (on the application of JL) v SSHD (2008) UKHL 68, the near suicide of a prisoner in custody which left him with the possibility of a long term serious injury automatically triggers an obligation on the state, under Article 2, to institute an enhanced investigation.

Langstaff J, in the earlier proceedings of JL, explained why an Article 2 compliant investigation was required where there had been a near death resulting in life threatening injury:

“So far as accountability is concerned, where a person is compelled by the coercive power of the state to be and remain in prison, there is a duty to account for his physical integrity which rests not simply on the civil or criminal law, nor just upon state agents, but upon the

state itself. Where the compliant may be made that a person knew, or ought to have known of a potential risk to life, it is easy to hold him accountable. Where, however, the system itself holds risks which are not apparent (and much may be revealed for the first time by a life threatening injury), no one person maybe held accountable. However, the lessons of history must be learned. The state needs not simply to hold individuals accountable, but to learn of potential systemic problems.”

The assault suffered by our client (which the police say was attempted murder) was so serious that it triggers an obligation on your client to conduct an Article 2 compliant investigation, of the same standard as an investigation into an actual killing.

Such an investigation should include (but not be limited to) consideration of the following issues:-

(a) The nature, quality and content of the intelligence that our client was at risk;

(b) The prior incidents that are related to his risk and assessment of risk;

(c) Our clients placement in segregation on 22nd July;

(d) The investigation of the incident on 22nd July;

(e) The decision making process up to and including 6th September, including the decision to place our client back onto a normal wing (C Wing);

(f) The supervision of prisoners' on association on C Wing (i.e. how prisoners' tried to kill our client and escaped onto another landing, apparently without being seen or stopped by staff);

(g) Prisoners' access landings (other than on their own when on association);

(h) The accessibility of razors and accountability for the possession of razors on C Wing (the police found two hidden weapons when the wing was searched after the 6th September assault;

The serious life threatening injuries suffered by our client have revealed the possibility of significant flaws in the system relating to the supervision and safety of prisoners' at HMP Whitemoor, and potentially the whole prison system. Whenever a near death occurs in custody, it is at least possible that the prison authorities have failed. In a system which is obliged to protect the lives of its

prisoners, the potential for risk to life indicated in this case clearly engages Article 2.

The type of investigation required

The object of an investigation held under the procedural duty imposed by Article 2, as well as determining the accountability of state authorities, is to:

- a) identify individual or system failings*
- b) open up the circumstances*
- c) correct mistakes*
- d) identify good practice*
- e) learn lessons for the future*

In order to fulfil its object, an Article 2 compliant investigation must be sufficiently thorough.

As our client's case is one where the lessons to be learned and policies to be reviewed are so similar to one where a death occurred, we consider that an investigation closely resembling an inquest is required. It is submitted that the investigation should:

- 1) be initiated by the state;*
- 2) be independent;*
- 3) be prompt;*
- 4) involve the victims family; and*
- 5) provide for a sufficient element of public scrutiny*

The above elements were considered in JL to be those necessary to fulfil the procedural obligation under Article 2 for an investigation into a near death through attempted suicide.

We consider that similar characteristics are required of your investigation in this case given the circumstances of the attack on our client and his persisting very serious medical condition.

It is essential that a compliant investigation is independent. When someone is assaulted in prison and receives life threatening injuries, there is an indication that the substantive obligations of the state may have been violated. Any violation whether systemic or operational, will inevitably involve members of the Prison Service. It is therefore necessary, in order to objectively determine whether

a violation has taken place, for those carrying out the investigation to be entirely independent of those who may have been implicated in the events.

The requirement of promptness is for the purpose of ensuring that the evidence is still fresh and the material witnesses are able to attend.

It is vital that our client and his family are able to participate in the investigation. In Amin [R (Amin) v SSHD [2004] 1 AC 653] one of the purposes of an investigation into a death was said to be that “those who have lost a relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.” We consider that this remains a vital aspect of an investigation even where no life has been lost. The victim, as well as his family members will find such serious injuries highly distressing. The knowledge that lessons learned could spare the life of a prisoner in a similar position will ameliorate this distress. Furthermore, our client and his family will have key information and evidence to contribute to the investigation.

We are of the view that any investigation which is Article 2 compliant must be public as far as the circumstances permit. The court in JL found that Article 2 did not necessarily require an investigation to be held in public but that it must provide for a sufficient element of public scrutiny. What is a sufficient amount of public scrutiny was held to vary from case to case. It is worth noting that the more public an investigation, the more public confidence in the systems adherence to the rule of law and intolerance of unlawful acts is maintained.

There is a clear public interest in exposing any systemic failings at HMP Whitemoor, a category A prison, which led to our client's injuries. The attack on him was serious and frenzied, apparently involving weapons which should not have been in the possession of his attacker(s). Not only were our client's attacker(s) able to severely assault our client with weapons, but they were able to do so undetected, which means that no charges will be brought against them.

Furthermore, this attack was at least the second serious attack on our client by other prisoners in HMP Whitemoor in a period of weeks. Our client is a long term prisoner in the category A estate. We understand that he probably remains at risk from prisoners who would do him further harm. Accordingly, the outcome of the

investigation will assist those making decisions about our client's future safety.

Those who have lost their liberty are a particularly vulnerable class in society and when they are let down in this way, the public has a right to be informed of the failings and the resolutions decided upon.

Current situation

We are aware that a police investigation was conducted. The police investigation on its own is not sufficient to comply with the procedural requirements of Article 2. Firstly, it completely fails to involve our client or his family and is conducted in private with no element of public scrutiny. Furthermore, it did not include an investigation of the systems in HMP Whitemoor in which the attack took place and the perpetrators escaped detection. Its purpose was merely to determine criminal liability and therefore cannot (and did not) delve into important matters such as systemic or operational failings and lessons to be learned. Neither are such matters the purpose for a future civil action (if appropriate). It is therefore our submission that a dedicated Article 2 investigation is required.”

- 4.10 From the documentation made available to the lead investigator, it would appear that Legal Practice 2 received no formal response from Treasury

Solicitors to the aforementioned correspondence until a period of almost five months had elapsed. It is not immediately clear why such a long period of time was required in order to provide a response.

- 4.11 The Ministry of Justice wrote formally to Legal Practice 2 in a letter dated the 16th October 2009, clearly indicating that this was a response to their letter of the 26th May. The bottom line of that letter was that the Ministry of Justice did not consider that the assault on Mr North engaged Article 2 of the ECHR and as a result did not necessitate an Article 2 compliant investigation. Once again for clarity and completeness the relevant sections of this letter are quoted below.

“I write, on behalf of the Secretary of State for Justice (SSJ), in response to your letter of 26th May 2009. You have asked the SSJ to conduct an investigation into the assault on your client Mr North that complies with the requirements of Article 2 of the European Convention on Human Rights [ECHR].”

“The SSJ recognised the importance of investigating serious incidents in prison, in particular, when a prisoner sustains serious long term injury as a consequence. As you have noted, Article 2 of the ECHR where it is engaged, requires an Article 2 compliant investigation with particular characteristics, including independence, promptness, a sufficient degree of public scrutiny, and the involvement of the individual and his or her family. Such

investigations generally arise in respect of a death where the acts or omissions of the state may have caused or contributed to that death. In certain limited circumstances however, an incident that has not resulted in a death can also require such an Article 2 compliant investigation.

The SSJ has carefully considered the relevant jurisprudence and has identified the circumstances in which incidents that have not resulted in a death can engage Article 2 of the ECHR and require an Article 2 compliant investigation. To engage Article 2 of the ECHR in this way, such incidents must:

- pose a real and immediate threat to the life of the individual involved; such as a suicide attempt that came close to success;*
- leave the individual involved with serious long term injuries; and*
- as a consequence of the long term injuries sustained significantly affect the ability of the individual involved to know, investigate, assess and/or take action in relation to the circumstances of the incident*

Having considered the evidence in respect of this case, in particular the medical report provided by Professor 1, it is not clear that the assault posed a real and immediate threat to Mr North's life. In any

event, the SSJ is not satisfied that Mr North has been left with serious long-term injuries; or that the injuries sustained by Mr North will significantly affect his ability to know, investigate, assess and/or take action in relation to the incident.

Accordingly, it is considered that the assault on Mr North does not engage Article 2 of the ECHR and as a result does not necessitate an Article 2 compliant investigation.”

- 4.12 On the 4th September 2009 Solicitor 2 advised and assisted Mr North in protecting his position by issuing civil proceedings in the High Court against the Ministry of Justice (MoJ) in order to comply with the one year limitation under the Human Rights Act 1998. On the 15th December 2009 the parties in the civil claim agreed to stay service of the Particulars of Claim to 31st March 2010, or three months after the conclusion of any Article 2/3 investigation. This remains the current position at time of writing.

4.13 On the 26th November 2009 as a consequence of the position adopted by the Ministry of Justice, as outlined in its letter of the 16th October, Legal Practice 2, on behalf of Mr North, served a letter before claim on the Head of Safer Custody and Offender Policy Group at the National Offender Management Service (NOMS). This was in recognition of the refusal to commission an Article 2 compliant investigation into the circumstances surrounding the assaults on Mr North.

4.14 As one might expect the letter before claim was a somewhat lengthy document that went into great detail in relation to:-

- The background surrounding the assaults in HMP Whitemoor and Mr North's period in segregation
- The injuries received as a consequence of the attacks on Mr North and his medical condition at that time
- The legal requirement and justification for commissioning an Article 2 compliant investigation
- What subsequent action was expected of the MoJ
- What pre-action disclosure was expected of the MoJ

4.15 The letter before claim concluded:

“Please provide a response and the information requested by 5:30 pm on Friday 11th December 2009.

If the matter is not resolved by that time, steps will be taken to prepare and issue an application for Judicial Review at the Administrative Court without further notice to you. Any claim will include a claim for legal costs. We will also be making an application for the matter to be expedited in order to avoid further delay.”

- 4.16 On the 6th January 2010 on the basis that no mutually acceptable resolution to the ongoing dispute had been established, Legal Practice 2 issued a Judicial Review claim with Statement of Facts and Grounds. Again, this is a comprehensive legal document and it serves no purpose to rehearse the contents again in great detail at this point. Many of the facts relating to the decision not to hold an Article 2 compliant investigation, and the challenges to the decision, have already been documented elsewhere in this report. The formal claim for Judicial Review was issued on the 11th January 2010.

- 4.17 By the 9th February 2010 the MoJ had changed its position with regard to commissioning an independent investigation in relation to the circumstances surrounding the injuries sustained by Mr North on the 6th September 2008. On that date a Consent Order withdrawing the Judicial Review application was signed by legal representatives of both parties.
- 4.18 The Terms of Reference for this Article 2 investigation, quite rightly, did not include a requirement to examine the position adopted by the Ministry of Justice with regard to its initial and prolonged refusal to commission an Article 2 compliant investigation. That is ultimately an issue to be debated and progressed via the legal process. That said, the delay between the attack on Mr North on the 6th September and the decision to commission an Article 2 investigation on the 9th February 2010, a period of some 17 months later, has probably had a significant detrimental effect on the quality and outcome of this investigation.
- 4.19 It is difficult to see how either the assault on Mr North in the gymnasium on the 22nd July 2008 or the assault in his cell on the 6th September 2008 failed to trigger an immediate formal investigation by staff at HMP Whitemoor. It is accepted by NOMS that no investigation took place into either incident. This is despite the severity of the injuries sustained by Mr North on both occasions.
- 4.20 There is no reason clear to the lead investigator as to why it took the Ministry of Justice (MoJ) some five months to reply to Legal Practice 2's

letter of the 26th May 2009 requesting an Article 2 compliant investigation. It is possible that this delay may have delayed progress unnecessarily and therefore had a negative impact upon the quality of the evidence that was subsequently made available to the lead investigator. It will be noted that some witnesses have not been able to recollect events and some key documents could not be located by NOMS.

- 4.21 There appears to have been no recognition or acceptance of the findings of the European Court case *Edwards v United Kingdom* (2002) 35 EHRR 487, 515, Para 86:

“The court reiterates that it is crucial in cases of deaths in contentious situations for the investigation to be prompt. The passage of time will inevitably erode the amount and quality of the evidence available and the appearance of a lack of diligence [will] cast doubt on the good faith of the investigative efforts, as well as drag out the ordeal for the members of the family.”

- 4.22 Thankfully, the assaults on Mr North did not result in death. However, the points made above by the European Court could apply equally to other non-fatal incidents in relation to the ability to identify and secure best evidence.
- 4.23 There appears to have been no recognition or acceptance of the recommendation (outlined in full above) by Mr Stephen Shaw, the then Prison and Probation Ombudsman for England & Wales, in his May 2008 report following his investigation after the case at the Court of Appeal in *R (D) v Secretary of State for the Home Department* [2006].

KEY FINDING 5. **A significant period of time elapsed between the two assaults on Mr North at HMP Whitemoor in July and September 2008, and the decision by the Ministry of Justice in February 2010 to proceed with an Article 2 compliant investigation. It cannot be judged with any degree of certainty what impact this passage of time had on the quality and outcomes of this investigation.**

RECOMMENDATION 1. If it has not already done so, HMP Whitemoor may wish to consider the benefits to be obtained from reviewing internal procedures and guidance for the management, recording and investigation under PSOs 1300, 2700 and 2750 of both prisoner on prisoner assaults and unexplained injuries. It may also be considered appropriate to reinforce any guidance with staff at the establishment in order to ensure an appropriate level of compliance.

CHAPTER 5.

NOMS INTELLIGENCE SYSTEMS AND PROCESSES

- 5.1 Before examining details of the events which resulted in injuries to Mr North, it is necessary to describe the systems which underpin the intelligence relating to Mr North and the events of July and September 2008. This chapter will describe those processes and explain that whilst all available intelligence is gathered and evaluated, not everything can be known about every situation before or during its development. It is not unusual for intelligence to become much clearer after an event or incident.
- 5.2 During interview, and as part of written submissions to the investigation, Mr North spoke about "*notes being put in the box*" which tended to indicate that he was at risk from attack. This process was explored in greater detail during interviews with managers and staff at HMP Whitemoor.
- 5.3 The lead investigator was informed that on the residential wings at HMP Whitemoor there were a number of boxes. There was an outgoing post box for external mail, a Samaritans box, and an Applications box. These boxes were maintained in a secure condition and always emptied by a member of prison staff. Although these boxes, at the time of this investigation, were emptied on a daily basis, it was suggested that back in 2008 they may have only been emptied once a week.

- 5.4 Although the boxes were not specifically intended as a mechanism for providing Intelligence, they were frequently used for this purpose. Prisoners used the boxes as a means of providing anonymous information. The lead investigator established that this is a common practice across the whole Prison Estate. It was stated that prisoners would write messages on any scrap piece of paper that they were able to obtain, and had a wide variety of motives for providing anonymous information via this process. Research often identified that the information provided was either without foundation or simply malicious. Examples provided included the desire to get another prisoner moved off the wing because it suited the author or because that individual had a better supply of drugs than the author of the note. On some occasions the author would provide inaccurate information about himself in order to try to secure a move to another part of the prison.
- 5.5 One of the Governors interviewed stated that on occasions it had been known for staff on the wing to put anonymous notes into the boxes in an attempt to influence management decisions. Their motives for doing so were usually around a desire to get a problematic prisoner moved off that wing in order to make their working day easier!
- 5.6 When the boxes were emptied, the Officer undertaking this task would put information from the anonymous notes on to a Security Information Report (SIR). The original note would be attached and it would then be

passed to the Security department. If appropriate to do so, the Officer should also make an entry in the wing Observations book summarising the information.

5.7 Upon receipt of the SIR and the note, the Security department would analyse the contents of the information alongside any other intelligence which it held. This would help inform any decisions regarding what action, if any, was necessary in order to manage the issues raised. The SIR would then go to the Security department Senior Officer for assessment and endorsement for appropriate action. The Security department would also sanitise the information in accordance with national standards and then enter the evaluated intelligence on to the prison's intelligence database. The original note would be removed from the SIR at this point. The original handwritten SIR would then be put on to the prisoner's security file.

5.8 Whilst it would be clear from the handwritten SIR that the information had originated from a note in the box, this should not be apparent when reading the sanitised version on the intelligence database. This process reflects the national standards used by all law enforcement and intelligence agencies for the recording and management of intelligence.

5.9 The lead investigator also explored the more general process of submitting SIRs by staff at HMP Whitemoor. As was the case then, when an Officer completes an SIR they are required to put their name

on it, sign it, and add the date and time that they complete the document. It should include details of the occurrence / information and list the names of any prisoners involved together with their prison numbers. The Officer should also state how the information recorded was obtained.

- 5.10 Staff then either hand deliver the SIR to the Security department or place the document in a mailbox for SIRs. If the information contained in the report is potentially urgent or high risk, then the documents should be hand-delivered as described above. In 2008, the mailboxes were located by the Orderly Officer's/Oscar's office which all staff passed on their way to and from the wings. For clarity, the role of the Orderly Officer/Oscar is to oversee the day-to-day operational running of the prison. The term Oscar is derived from their radio call sign, Oscar. There is also a mailbox at the main gate. These were emptied twice daily at approximately 08.30 hours and 13.30 hours. As described above, the reports were then processed and actioned by the Security department.

- 5.11 On a daily basis, at HMP Whitemoor, one of the functions of either the Security Governor or the Duty Governor was to sign off all of the new SIRs in order to quality assure the assessment of the information and the action that had been either carried out or was proposed. If the information submitted on the reports was high impact or high risk, then this would be highlighted with management at the earliest opportunity. The lead investigator was informed that for routine matters the whole process around SIRs, from the initial submission through to Governor's sign-off, should take no longer than 72 hours.
- 5.12 It was confirmed that prisoners' security files were maintained under secure conditions in the Security Office with strictly limited access. The keys for the Security Office were held within the establishment's key safe and access to the Intelligence Office was strictly restricted by use of a coded key pad. In addition to other measures in place, this assisted in protecting the integrity of the information and is a requirement in order to comply with national minimum standards for managing intelligence material.
- 5.13 As part of the investigation the lead investigator interviewed the Lead Intelligence Trainer for NOMS. He works as a member of the training team at the Prison Service College, Newbold Revel, Warwickshire.
- 5.14 He informed the lead investigator that the intelligence systems operate in exactly the same way across the entire Prison Estate across England

and Wales. The processes are no different in young offender establishments to those in the High Security Estate. He confirmed the process described above for the submission and management of SIRs as being a generic process for the entire Prison Service.

5.15 Helpfully, he was able describe in some detail the process for the sanitisation and management of SIRs. Sanitisation is a means of removing the identities of sources of information or the details of any tactics that have been used in order to obtain the information. The sanitised intelligence report should be written in a way that recipients of the report have enough information to act on if necessary but does not identify the origins or tactics. Sanitisation is also used to manage physical risk to Human Sources and to manage human rights and data protection issues.

5.16 It was identified that within established working practices the process of sanitisation can be carried out by anyone working within the Intelligence department who has had the appropriate level of training. Within the High Security Estate this would always be a skilled and experienced Intelligence Officer.

- 5.17 At the time of the attacks on Mr North in 2008, NOMS operated an IT-based intelligence system in each prison. The systems were not networked and there was no facility for staff to access intelligence held by other establishments. All of the staff interviewed as part of this investigation saw this as a significant problem when it came to the timely sharing of intelligence on prisoners between establishments. This became particularly relevant when a prisoner was transferring from one establishment to another.
- 5.18 Consequently, the process in place in 2008 was that when a prisoner moved from one prison to another, his hard copy Security file was transferred to the receiving establishment. Dependent upon the background of the prisoner, his time in custody and his offending history, these files could be substantial documents consisting of several volumes. This was the case in respect of Mr North. In practice the files might not have been received by the new establishment holding the prisoner for approximately a week after a prisoner's arrival. Any urgent or particularly relevant intelligence was routinely sent via electronic means from the transferring establishment to the receiving establishment in order to assist with the management of any ongoing issues around risk, for example, where the prisoner should or shouldn't be located within the establishment or from whom he needed to be isolated.

- 5.19 In addition, any relevant risk-based information was flagged up by the transferring establishment to the receiving establishment via the Prisoner Escort Record (PER) that the Intelligence department would complete prior to transfer. This would be handed over to the receiving establishment on the prisoner's arrival. In the main this would only record serious and immediate risks.
- 5.20 From the information and records made available to the lead investigator, there is every indication that all of the aforementioned generic processes around the recording and management of intelligence were properly utilised in respect of Mr North. This includes his frequent transfers between establishments across the High Security Estate.
- 5.21 During the course of this investigation it became clear that NOMS had already acknowledged the significant shortcomings of its intelligence system, in particular the inability of one establishment to view, with appropriate permissions, intelligence held by other establishments. This arrangement was clearly at odds with the principles of the Bichard Inquiry, which although focused on the Police Service, raised a number of generic issues around the improved sharing of information in order to facilitate appropriate levels of public protection.

- 5.22 The then Director of High Security Prisons confirmed that in October 2010 NOMS' Executive Management Committee had approved the commencement of work aimed at creating a new networked intelligence system. This work would progress under the name "Project Mercury".
- 5.23 At the time of writing this report it has now been confirmed that "Project Mercury" is almost complete. A networked intelligence system is in the process of being rolled out to all establishments across the Prison Service, with the High Security establishments being the first to go live. The Lead Intelligence Trainer confirmed that once the project is finalised, prisons will be able to share intelligence by request to the prison which owns the intelligence. Both prison staff and the lead investigator see this as a significant step forward in how NOMS manages and shares intelligence.
- 5.24 It should be noted that the lead investigator has not found any evidence to suggest that there were any failings in the intelligence systems or processes in place in 2008 or that they in any way contributed to the events involving Mr North.

CHAPTER 6.

SAFER CUSTODY SYSTEMS AND PROCESSES AT HMP WHITEMOOR

- 6.1 In accordance with PSO 2700 Suicide and Self Harm and PSO 2750 Violence Reduction, HMP Whitemoor had in place procedures and practices for ensuring the safety of prisoners, staff and visitors, managed by the Safer Custody function within the prison. In 2008 Principal Officer 1 was Head of Safer Custody, with Senior Officer 1 in post, as of March 2008, as the Safer Custody Co-ordinator.
- 6.2 Primarily, the Safer Custody portfolio was about promoting a safer prison through Assessment, Care in Custody and Teamwork (ACCT). Safer Custody policy requires prisons to identify prisoners who may pose a risk of harm to self and those who pose a risk to others. Prisoners identified as a risk of harm to self were managed using ACCT procedures, then set out in PSO 2700. Prisoners identified as a risk of harm to others were managed using the Violence Reduction procedures. The role of the Safer Custody team at Whitemoor included monitoring incidents, taking forward procedures associated with suicide and self-harm prevention, working to reduce incidents of violence and bullying, the latter forming part of HMP Whitemoor's local Violence Reduction Strategy.
- 6.3 During the course of this Investigation there has been an attempt to seek some clarity around ongoing Safer Custody issues that had been raised

by HMCIP during the 2006 and 2008 Inspections. In particular, it appeared that there may have been some confusion amongst staff at the prison around what constituted an assault and what amounted to an unexplained injury. During interviews with staff it appeared that there was a clear understanding that unexplained injuries were quite literally that. They were unexplained. Injuries clearly sustained as a result of an assault should not be recorded, or managed, as unexplained.

- 6.4 The role of Safer Custody Co-ordinator included monitoring all cases of assaults, injuries, bullying and self-harm. Every month the Co-ordinator produced a report of such incidents for the Safer Custody Meetings.
- 6.5 Post the HMCIP Report it was suggested that all cases of unexplained injury were in the first instance reported to the Safer Custody Co-ordinator. However, responsibility around any investigation in order to establish the facts around how the prisoner had sustained the injury remained with wing staff.
- 6.6 The Safer Custody Meetings in 2008 were described as being multi-disciplinary with a wide variety of representation. Attendance would invariably include representatives from all residential wings, Chaplaincy, the Independent Monitoring Board, Security and Head of Residence. At that time prisoners known as Listeners used to attend the meetings. Listeners are prisoners who are selected, trained and supported by the

Samaritans to listen in confidence to fellow prisoners who may be experiencing emotional distress.

6.7 During the course of interviews with both Principal Officer 1 and Senior Officer 1 it became clear that the meetings in 2008 struck a balance between Safer Custody, probably more accurately described as welfare matters, and violence reduction. It emerged that the violence reduction issues probably did not get the exposure that they merited as individual cases could not be discussed due to the presence of the Listeners.

6.8 Eventually this was recognised as an issue and the two meetings were separated, with the Listeners being returned to their wings in advance of any discussions around violence reduction taking place. However, it would appear from the information available that during the time of the assaults on Mr North both elements of the meeting remained as one. Consequently, individual cases of violence were not discussed in any detail. This was recognised as being far from ideal. In addition the meeting also worked on data that was a month in arrears. So for example, the August meeting would be discussing events that took place during June. Clearly, this made timely action to manage individual cases difficult.

6.9 At the time of investigation the format of the Safer Custody meetings had changed. Every incident was by now discussed separately and in some detail. The victims were actually named and so it was clear to everyone

present what case was being discussed. Every assault was discussed at Safer Custody Meetings, including prisoner on staff assaults. In addition, the Safer Custody Co-ordinator now had access to the Incident Reporting System (IRS) which provides a facility for direct searching of the database for relevant assaults and unexplained injuries.

- 6.10 The procedures in place at HMP Whitemoor in 2008 were such that both the Safer Custody Co-ordinator and the Safer Custody Committee would and should be notified of all unexplained injuries to prisoners and assaults on prisoners across the establishment. It became clear as part of this investigation that this process did not happen in the way it should have done in respect of the assaults on Mr North. Of particular concern was the fact that it was highlighted that some areas of the prison, for example the gymnasium, appeared to operate in isolation and did not report incidents of assault into the Safer Custody process. It was even suggested that at the time of investigation, in 2011, that this had not changed.

- 6.11 During interview with the lead investigator the Safer Custody Co-ordinator confirmed that she was never made aware of the assault on Mr North in the gymnasium on the 22nd July 2008 even though she should have been. She stated that she was absolutely confident of this because on a monthly basis she was required to produce a report for the Safer Prisons Team and the Senior Management Team. That assault is not mentioned in those reports.
- 6.12 The minutes for the Safer Custody meeting held in October 2008 make brief reference to the attack on Mr North in the gymnasium on the 22nd July 2008. It would appear that the incident was discussed briefly but only in general terms. Mr North was not mentioned by name and no obvious follow-up actions arose from the discussions. What should be noted is that by the time of that meeting in October Mr North had been the victim of a second and far more serious attack, on C wing on the 6th September 2008.
- 6.13 Senior Officer 1 confirmed that the Safer Custody Meetings and Key Performance Targets (KPTs) were already in place when she commenced the role of Safer Custody Co-ordinator in March 2008. Helpfully, she was able to confirm to the lead investigator what constituted a serious assault for KPT purposes. It was defined as “*An assault is serious if it is a sexual assault, results in detention in outside hospital as an in-patient, 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, broken tooth, cuts requiring suturing, bites, temporary or permanent blindness.” Senior Officer 1 confirmed that in her judgement the attack on Mr North on the 22nd July 2008 clearly constituted a serious assault within the KPT definition and should have been reported and managed accordingly. She reinforced a previously expressed opinion that the initial responsibility for all aspects of the incident, including scene management and investigation, rests with the Orderly Officer (Oscar 1).

- 6.14 Senior Officer 1 conceded that, with hindsight, in 2008 unexplained injuries and assaults were clearly falling through the gaps. She was however confident that things had improved considerably since that time due to a number of factors. These include her ability to research the IRS, and far better communication and understanding of her role between all departments across the prison. The prison Control Room now notify her direct, even when she is off duty, of incidents that form part of her remit. The Safer Custody Co-ordinator now collates all cases of unexplained injury and assaults separately and reports on them accordingly. Assaults are dealt with by a different process with greater involvement from the Security department. In addition she now attends the Security Committee meetings and she is required to produce a report for attendees documenting every assault that has taken place in the establishment since the last meeting.

6.15 Both Principal Officer 1 and Senior Officer 1 also made reference to the fact that for a number of years pre 2008, HMP Whitemoor had not met targets for reduction in serious assaults and following comment by HMCIP, steps had now been taken to address this matter. This included the introduction of a new Violence Reduction Strategy.

RECOMMENDATION 1. If it has not already done so, HMP Whitemoor may wish to consider the benefits to be obtained from reviewing internal procedures and guidance for the management, recording and investigation under PSOs 1300, 2700 and 2750 of both prisoner on prisoner assaults and unexplained injuries. It may also be considered appropriate to reinforce any guidance with staff at the establishment in order to ensure an appropriate level of compliance.

CHAPTER 7.

HISTORICAL INTELLIGENCE

7.1 Mr North commenced his current term of imprisonment in February 2001, initially on remand, for the offences of which he is now convicted. Since that time he has moved around the Prison Estate on a regular basis, the details of which are listed below:

09.02.2001	Wandsworth
15.02.2001	Belmarsh
23.07.2001	Woodhill
25.09.2001	High Down
05.11.2001	Belmarsh [Sentenced 05.02.2002]
11.09.2002	Whitemoor
06.01.2003	Long Lartin
05.11.2003	Full Sutton
26.10.2004	Frankland
19.05.2005	Long Lartin
08.02.2006	Belmarsh
21.03.2006	Long Lartin
11.07.2006	Full Sutton
11.01.2007	Whitemoor
26.06.2007	Frankland
24.10.2007	Full Sutton

03.07.2008 Whitemoor

17.12.2008 Prison 1

7.2 In September 2010 an intelligence report, produced for the lead investigator by the Intelligence Unit at Full Sutton, documented the associations of Mr North, and related intelligence, for the period January 2007 through until February 2008. In summary the intelligence report concluded that:

- Mr North was linked to several prisoners who were believed to have affiliations with a London-based gang
- there was animosity between this group and another London-based gang
- contracts were being taken out on Mr North, and Mr North was also taking out contracts to assault other prisoners. It was suggested that these contracts related to both Full Sutton and Whitemoor
- Mr North was involved in a fight at Whitemoor in March 2007
- Mr North was believed to have been involved in an act of disorder at Full Sutton in November 2007

7.3 On or around the 12th January 2007 several pieces of intelligence were received by the Security department at Whitemoor which tended to indicate that Mr North was in dispute with other prisoners.

- An Officer noticed that there appeared to be tension at Muslim prayers between Mr North and another prisoner. It was noted that a third prisoner attempted to act as mediator.
- In the exercise yard a prisoner was heard to shout words to the effect of “*tell North that he is the last thing on my mind*”.
- Information from a prisoner to an Officer stated that Mr North had enemies. The prisoner would not name them. He also stated that he personally “*hated his Mr North’s guts*”.

7.4 It is worthy of note that Mr North only arrived at Whitemoor on transfer from Full Sutton the previous day, the 11th January 2007.

7.5 As a result of the aforementioned emerging issues, on or around the 17th January 2007 Mr North was interviewed by staff from the Security department regarding potential threats to his safety. During at least one, but more likely two or three, such meetings Mr North stated that as far as he was concerned everything was fine.

7.6 Both within a pre-prepared statement and during interviews with the lead investigator, Mr North made reference to the alleged threats to his safety

and to subsequent interviews with Security staff. He particularly remembered that one of the staff that spoke to him about these matters was Senior Officer 2. Mr North recalled how he was told that notes had been put in the box on the wing saying that if he was not moved then he would be killed. When asked what was happening, Mr North stated that he didn't know.

7.7 The lead investigator spoke with Senior Officer 2. He confirmed that he worked at HMP Whitemoor between 2005 and April 2008 and that during a period in 2006/07 he was the Security SO in the Intelligence office. Given the passage of time, Senior Officer 2 had no recollection of either Mr North himself or the events connected with this investigation.

7.8 However, in discussing wider issues, Senior Officer 2 stated that it is fairly commonplace in prisons, particularly across the High Security Estate, for attacks to be carried out by associates as opposed to the main protagonists themselves. Consequently, in many cases it is almost impossible to identify in advance where a 'hit' might come from.

- 7.9 On the 17th January 2007 there was further intelligence received suggesting that Mr North had three 'hits' on his head. It specified that two were from B wing and one from A wing. The information appeared to be non-specific, other than this was due to previous incidents between Mr North, his associates, and other prisoners.
- 7.10 On or around the 23rd February 2007 intelligence was received suggesting that Mr North had himself taken out a contract against another prisoner. As a consequence of this information the prisoner was subsequently moved for his own protection.
- 7.11 On the 1st March 2007, whilst still at Whitemoor, Mr North had what he described as a "*disagreement*" with a Muslim prisoner in the Education department. Mr North was stabbed in the hand during this encounter and still has a scar from the injury. Mr North states that he was specifically targeted by his assailant as he did not get on with some of his (Mr North's) associates. He is clear that in his opinion this particular attack was not about race or religion.
- 7.12 As a consequence of this altercation Mr North was segregated and charged under Prison Rules with fighting. At a subsequent adjudication hearing the charge was found 'Proved'. After a period in the Segregation Unit he was subsequently transferred out of Whitemoor to Frankland.
- 7.13 On or around the 16th March 2007, whilst Mr North was still at Whitemoor, intelligence was received stating that as a consequence of

the fight in Education, there was now a contract out on him. It was suggested that some prisoners had already come forward offering to carry out the assault. At or around the same time Mr North was again interviewed by Security staff about these potential threats to his safety. It is recorded that as a result of the conversation Mr North stated that he was not under threat and did not want to be segregated. On this same matter, an Officer submitted a report stating that Mr North appeared quite unconcerned about these threats against him and upon returning to his cell he readily informed other prisoners that he had been offered segregation for his own protection.

7.14 There is an intelligence report dated the 15th May 2007, again whilst Mr North was still at Whitemoor, stating that he had access to a mobile telephone and received calls from a prisoner located at Long Lartin. It was stated that this prisoner had himself been previously attacked whilst located at Whitemoor. The intelligence stated that the prisoner at Long Lartin had organised reprisal attacks against some named prisoners who were associated with the individual who had attacked Mr North in Education in March. It was noted that the attacks had yet to take place.

7.15 As stated above, Mr North was transferred out of Whitemoor to Frankland on the 26th June 2007. He only remained there for a brief period and was then transferred to Full Sutton on the 24th October 2007. He remained there until his transfer back to Whitemoor on the 3rd July 2008.

- 7.16 On or around the 6th November 2007 and 11th November 2007 there were two separate pieces of intelligence indicating that Mr North, by now located at Full Sutton, together with a fellow prisoner had been involved in an assault on another prisoner at the establishment.
- 7.17 In a pre-prepared statement Mr North stated that in 2007, whilst at Full Sutton, a new rule was introduced which meant that prisoners could not have any physical contact with their visitors, therefore the chairs in the visits area were moved further apart. As Mr North is hard of hearing in one ear, this made communication very difficult for him. As a consequence of this new rule, together with other prisoners, Mr North was involved in a sit-down protest on his wing. He stated that the Governing Governor came down a short time later and indicated that he was not aware of the new rule. He stated that if the prisoners 'banged up' he would sort the matter out. Mr North further stated that the following week he was amongst a group of prisoners who had an audience with the Governor to discuss the matter and as a result the practice was revoked.
- 7.18 Within this same statement Mr North described an occasion when a prisoner, who he described as a prominent Muslim, said that those who didn't take part in the protest should have their cells set alight. Mr North stated that both he and other prisoners refused to agree to this course of action as, in his opinion, participation in the protest or otherwise was a matter of personal choice. He was of the firmly-held view that the other prisoners should not be bullied.

7.19 A short time later, in around November 2007, the previously-mentioned Muslim prisoner was assaulted and had his jaw broken. Mr North became a key suspect for this attack but remains insistent that he was not involved. Despite Mr North's claims that he was not involved in this attack, some hours afterwards he, and others, were sent to the Segregation Unit. He states that it was at this point that he was threatened with being sent to the Close Supervision Centre at HMP Woodhill. The account given by Mr North states that the victim of this assault told the Governor at Full Sutton that he (Mr North) was not involved in the breaking of his jaw but other prisoners on the wing stated that he was. The Governor stated that he did not believe the account provided by the victim.

- 7.20 It should be noted that Mr North was never convicted of any involvement in this attack, either via the Criminal Justice System or prison discipline. Given that Mr North did subsequently make reference to his involvement in this assault almost immediately after he was attacked on the 6th September 2008, the lead investigator did attempt to interview the victim of the broken jaw attack but he declined the interview.
- 7.21 In early February 2008, whilst Mr North was still resident at Full Sutton, intelligence was received suggesting that Mr North had again been involved in an assault on another prisoner. A few weeks after this there was further intelligence indicating that he was involved in the making and holding of weapons.
- 7.22 Again in a prepared statement Mr North stated that in April 2008 there was a protest in the workshop at Full Sutton. This protest was over pay and as a consequence he refused to carry on working there. He states that he was then sent to the Segregation Unit both for refusing to work and also because he was suspected of paying another prisoner to pour hot oil on a Senior Officer. Mr North was clear that this was not the case and he was never charged with either a criminal or disciplinary offence in relation to that matter. At around the same time as this issue, intelligence was also received suggesting that Mr North and another prisoner were involved in trying to cause unrest on the wing.
- 7.23 The lead investigator interviewed Governor 3. Governor 3 at that time was a Governor Grade member of the prison Management Team and

Deputy Head of Security at Full Sutton. In this post he also held responsibility for the Intelligence function at the prison. During the period when Mr North was located at Full Sutton in 2007/08 Governor 3 was Governor for the main wings and Segregation Unit. In effect he was Governor with immediate responsibility for Mr North.

7.24 Governor 3 told the lead investigator that he knew Mr North very well and indeed Mr North was very well known around the High Security Prisons. During his last period of residence at Full Sutton in 2007/08, Mr North had been removed from the main wings to the Segregation Unit on four separate occasions over an eight month period. On each occasion this was for reasons of good order and discipline.

7.25 Governor 3 described Mr North as being a particularly difficult prisoner to manage and as a consequence, he got moved around the High Security Estate on a regular basis. In his opinion he considered him to be amongst the top ten per cent of most difficult prisoners to manage across the High Security system. He described Mr North as being used by the gangs that were active across the High Security Prisons as “*a bit of a hit man, an enforcer!*” He stated that at no time could he ever recall Mr North being under any sort of personal threat at Full Sutton. In his opinion he was always the perpetrator, never the victim.

7.26 He believed that Mr North was paid by others to carry out assaults and in his opinion was not too fussy who he did it for. He considered that Mr North actually enjoyed carrying that type of reputation. In his view Mr

North would have been comfortable walking into any of the High Security Prisons, even when amongst people whom he had already assaulted. He considered that Mr North was that comfortable both with his ability and reputation.

7.27 Helpfully, Governor 3 also spoke to the lead investigator in some detail about the emerging influence of 'Muslim gangs', particularly across the High Security Prisons. He stated that it was about 2007/08 that these gangs started to take hold, becoming some of the most prominent in prisons. At this time lots of people were trying to convert high-profile prisoners to the Muslim faith in order to make the overall gang bigger and stronger.

7.28 He considered that 'Muslim gangs' are now the biggest and most influential across prisons, in particular dominating the High Security Estate. In his words, "*consequently the world for Mr North changed a bit*".

7.29 Referring back to his arrival at HMP Whitemoor post 3rd July 2008, in his pre-prepared statement Mr North stated that there was a rumour going around that he had refused to take his Shahadah and convert to Islam. He stated that there was pressure across the board from Muslim prisoners to convert to Islam. Other prisoners were coming up to him and telling him just to take the Shahadah and join the brotherhood. His position remained that he was not religious and would not pretend to

pray. He was clear that his family was not Muslim but Christian and he was not prepared to pretend to convert.

CHAPTER 8.

ARRIVAL AT HMP WHITEMOOR – 3RD JULY 2008

- 8.1 Mr North arrived at HMP Whitemoor, on transfer from HMP Full Sutton, on the 3rd July 2008. During his sentence Mr North had spent two previous periods at Whitemoor. In 2002/2003 he was at the establishment for some five months, and in 2007 for a period of some six months.
- 8.2 Prior to his arrival at Whitemoor on the 3rd July 2008, Mr North had been in HMP Full Sutton for a period of some eight months, since late October 2007. During that time he had spent a significant period of time (April until July) located within the prison Segregation Unit for reasons of good order and discipline. Mr North had considered this to be an unfair and unjustifiable course of action and via his then solicitor, Solicitor 1 of Legal Practice 1, was preparing to take this matter to Judicial Review. Mr North's transfer to HMP Whitemoor was aimed at resolving the need for his ongoing segregation.
- 8.3 Upon Mr North's arrival at HMP Whitemoor staff at the prison completed both the Reception Induction Form and the First Night Induction Form as per standard procedure for any new arrival at the establishment. In respect of the Reception Induction Form, Mr North signed the document confirming that he had no issues of concern in relation to him being located at that particular prison. As regards the First Night Induction

Form, he signed confirming that he understood all of the information contained within that document.

8.4 Following his initial induction Mr North was moved to C wing. At this time C wing was used to hold all new arrivals at the establishment. The Location History Record shows that following Mr North's arrival on the wing, timed at 18.49 hours, he was allocated cell C3-015 which is on Blue Spur.

8.5 At approximately 19.05 hours that evening a general alarm was sounded on C wing Green Spur. This incident was totally unconnected with Mr North. As is normal practice when such alarms are sounded, prisoners started to make their way into their individual cells and staff began overseeing that process and engaging with any prisoners who required encouragement to return to their cells. All of this is recorded on the Wing Movements Log. This document also records the fact that at around the same time as the incident referred to above, Mr North refused to return to his cell when asked to do so by Officers and he was subsequently removed, under restraint, to the Segregation Unit. The C Wing High Risk and Standard Category A Movements Sheet notes that Mr North was moved, as described above, at 19.15 hours. The Location History Sheet referred to previously records Mr North's arrival in the Segregation Unit at 19.28 hours at which point he was located in cell S1-007.

8.6 The lead investigator has examined the Use of Force Form relating to the aforementioned incident and this record confirms that Mr North

refused to lock up during an alarm bell and that he became both non-compliant and violent. It took five staff under the supervision of Principal Officer 2 (Acting), using approved Control and Restraint (C & R) techniques, to bring Mr North under control and to remove him from the wing. These Officers described Mr North's violent conduct which occurred when Officers had to forcibly remove his hand from the landing railings in an attempt to return him to his cell. There is no information recorded on the Use of Force Form explaining why Mr North did not want to return to his cell. No Officers were injured as a consequence of this incident and upon his arrival in the Segregation Unit Mr North informed the duty nurse that he had sustained no injuries and was fit and well.

- 8.7 Following his relocation to the Segregation Unit, Mr North was charged by Officer 1 with failing to obey a lawful order at 19.15 hours on the 3rd July 2008 on C wing Blue 2s landing, namely for refusing to return to his cell when instructed to do so. Such a charge is contrary to Rule 51 (Offences against discipline), Paragraph 22 of the Prison Rules. It was subsequently arranged for Mr North to appear at an adjudication hearing on the 5th July 2008. When Officer 1 was interviewed by the lead investigator, given the passage of time, he only had a vague recollection of this incident involving Mr North. He was able to recall Mr North holding on to the landing railings and refusing to lock up. He was unable to remember what the incident was about or any conversation with Mr North.

- 8.8 The adjudication hearing was held at 10.00 hours on the 5th July and was chaired by Governor 4. The Adjudication Report [Form F256] records the fact that when the charge was read to Mr North he indicated that he understood the allegation, that he did not require legal representation and that he did not wish to call any witnesses. He entered a plea of 'guilty' to the allegation. When asked by Governor 4 why he had refused the order Mr North replied by stating that he "*wanted to come down the seg as I don't get on with prisoners on there*". At Governor 4's suggestion, Mr North agreed that he should be relocated to A wing. The charge was found to be 'Proven' and by way of penalty Mr North received 75 per cent stoppage of earnings for 21 days suspended for three months, 21 days loss of canteen suspended for three months, 21 days loss of Association suspended for three months and 21 days loss of television suspended for three months.
- 8.9 Following the adjudication hearing on the 5th July, Mr North was transferred to A wing and located in cell A2-023 where he remained until a return to the Segregation Unit on the 22nd July 2008.
- 8.10 Mr North was first interviewed by the lead investigator in Prison 1 on the 3rd December 2010. Also present at the interview was his legal representative from Legal Practice 2 Solicitors, Solicitor 3. During this interview Mr North stated that at the adjudication hearing on the 5th July 2008 he had told Governor 4 that he was not safe on C wing "*cause of an argument last time*". This was a reference to when he had been assaulted by two prisoners at HMP Whitemoor in March 2007 because

of an ongoing dispute with another prisoner. During that attack Mr North had received minor stab wounds to his hand after he had been stabbed with an improvised knife or bladed instrument. That incident has been covered in Chapter 7.

8.11 During this interview on the 3rd December 2010, Mr North provided an initial account of events surrounding his segregation on the evening of the 3rd July 2008. He stated that he was on C wing Blue Spur when he saw a couple of people whom he recognised on the adjoining Red Spur. He was aware that they had been involved in the attack on him in March 2007 and that they had an established association with the person with whom he originally had the dispute. Seeing these individuals caused him to fear for his safety if he was to remain on the wing. Mr North described how the alarm bell then sounded for another unconnected incident on the wing. He made the decision that he was going to relocate to the Segregation Unit and when asked by Officers to return to his cell he refused to do so due to concerns for his safety. He confirmed during interview that he told staff that he was going to the Seg; he also stated that he had actually packed his bags with the intention of moving. These actions were to a degree corroborated by Officer 1 during his interview with the lead investigator. Mr North described the men that he feared, stating that they were black and mixed-race or Asian. He knew them through the prison system and also knew that they were from Birmingham. He didn't know them by name but stated they were known for putting out 'hits' on people.

- 8.12 During that interview Mr North could not recall if he had mentioned his fears to the Officers who removed him from C wing on the night of the 3rd July 2008. He was quite clear that he had expressed his real fears to Governor 4 during the subsequent adjudication hearing on the 5th July. He stated that when Governor 4 asked him why he had done it, namely refused to return to his cell, he stated “*because my life is under threat on that wing and I don’t want to stay on there.*”
- 8.13 When Governor 4 was interviewed by the lead investigator he confirmed that he had indeed chaired Mr North’s adjudication hearing on the 5th July 2008. He was shown a copy of the Form F256 Record of Adjudication Hearing and he confirmed the handwriting as being his. He also confirmed the record of the discussion as per box 14 on the document, but he could not recall any detailed conversation about Mr North’s safety over and above that what is recorded. Where Governor 4 was very clear was that if Mr North had specifically said that he thought that his life was under threat, as has been suggested, he would have submitted an Intelligence Report to the Security department and recorded what had been said on the Record of Adjudication Hearing report. Governor 4 saw this as being very different to comments around having issues with people on the wing, which he described as an everyday type of activity at HMP Whitemoor, given the type of prisoners who are located there.
- 8.14 During the course of this investigation, the lead investigator has had sight of intelligence material dated the 4th July 2008 which indicated that

Mr North's refusal to lock up when asked to do so on the evening of the 3rd July 2008 was due to the fact that he had not been supplied with a television set for his cell and that he had indicated earlier in the evening that he would refuse to lock up unless this was rectified.

- 8.15 Mr North was interviewed by the lead investigator on a second occasion on the 14th May 2013. The aforementioned information regarding his lack of television was put to him during the course of the interview. He was quite clear that this information was inaccurate and he would not subject himself to a further period of segregation for such a trivial reason, especially given that he had moved to Whitemoor from Full Sutton following a lengthy period in the Segregation Unit there. He could offer no explanation for that suggestion, stating that televisions were freely available on the wing and one would have been made available to him in the very near future should he request one. Mr North was again quite clear around his reasons as to why he had refused to return to his cell, and provided an almost identical account to the one that he gave in his first interview. The area where his account at his second interview did differ slightly from the one he gave in his first interview, was regarding Governor 4's account of the conversation at the adjudication hearing. Mr North conceded that he could not recall what he actually told Governor 4 at the hearing on the 5th July 2008. He firmly believed that he made it clear that he felt threatened. He could not now recall if he actually told Governor 4 that he considered that his life was at risk. He accepted that maybe he could and should have done more at this time to help staff at HMP Whitemoor manage any ongoing risk to his safety.

8.16 On the 4th July 2008 whilst Mr North was located in the Segregation Unit awaiting his adjudication hearing, staff at HMP Whitemoor received a letter from Legal Practice 1 regarding his treatment. In essence, Legal Practice 1's letter requested an urgent explanation as to why their client had once again been removed from the main wing to the Segregation Unit. They appeared to be making a clear link between his periods of segregation at Full Sutton with recent events at Whitemoor. Governor 5 subsequently replied to Legal Practice 1 in a letter dated the 8th July 2008, setting out exactly what had happened and what was now expected in relation to Mr North's future conduct whilst at Whitemoor.

8.17 When interviewed by the lead investigator around a number of aspects of this investigation, Governor 5 made specific reference to the communications received by the prison from Legal Practice 1. She stated that as part of her role at Whitemoor she received and dealt with large amounts of correspondence from different solicitors, most of which she does not specifically remember in the long term. However, the tone and the content of Legal Practice 1's letter of the 4th July had stuck in her mind. She stated that she remembered it well as she considered it to be totally out of proportion to the issues it was raising. She considered it to be ill-informed, histrionic and paranoid. The role of Legal Practice 1 and their representation of Mr North's interests in this particular case will be further examined later on in this report.

8.18 Following the examination of documents and interviews with relevant members of staff, the lead investigator is of the opinion that Mr North was received and integrated into HMP Whitemoor on the 3rd July 2008 in accordance with established policies and procedures. This includes his removal to the Segregation Unit on the evening of the 3rd July 2008 through to his adjudication hearing on the 5th July 2008 and his subsequent relocation to A wing later that same day. Whilst accepting that prison life and prison culture can make life very difficult for prisoners who feel threatened and at risk from other prisoners, it is clear that Mr North could and indeed should have handled the situation differently if he genuinely felt that he was at risk from other people on the wing. It is clear that staff can only provide adequate protection from risk if they are properly made aware of all relevant information. The first time that there appears to be any degree of certainty that Mr North engaged with prison staff on this matter was at his adjudication hearing on the 5th July 2008. At that time, despite uncertainty around exactly what was said, Governor 4 appears to have taken all reasonable steps in the circumstances to agree to Mr North's wishes and move him to an environment where he felt safe, namely A wing.

8.19 The only observations for consideration that the lead investigator would make in respect of this part of the Article 2 investigation relate to minor issues of record-keeping. Firstly, examination of the C wing Observation Book in relation to the 3rd July 2008 revealed that it contained no reference to the incident involving Mr North and his relocation to the Segregation Unit. The lead investigator considers that it would be good

practice for incidents of this nature to form part of such records. Secondly, when the lead investigator requested a copy of the associated Incident Report for Mr North's relocation from the wing to the Segregation Unit it could not be located. The Head of Security at HMP Whitemoor notified the lead investigator by letter that a thorough search had been made for the document but it could not be found. If it has not already been considered, managers at HMP Whitemoor may wish to review the process for the completion, oversight and storage of official documents relating to significant events at the establishment. Further examples of missing records are highlighted elsewhere in this report.

RECOMMENDATION 2. If they have not already done so, NOMS and HMP Whitemoor should consider if current procedures and staff training provide for the full and accurate completion of official prison documents. Adequate audit and storage arrangements should also be considered as part of any subsequent review. The investigation highlighted a high number of either incomplete, or missing, official prison records. HMP Whitemoor should consider the policy on retaining both draft and final copies of letters and ensure that a process is in place to readily differentiate between draft and final versions of documents.

CHAPTER 9.

ASSAULT IN GYM AT HMP WHITEMOOR – 22ND JULY 2008

- 9.1 Following his adjudication hearing on the 5th July 2008, Mr North was moved from the Segregation Unit to main location within the prison. Records show that from 15.48 hours that afternoon he was located on A wing in cell A2-023. Mr North told the lead investigator during interviews that he felt safe during this period of residence on A wing. Mr North stated that there were no threats made to him by other prisoners during this time, although one or two prisoners did tell him that he should just go ahead and take the Shahadah which was something that he continued to refuse to do on the grounds that he was actually Christian. In addition, Mr North was not made aware by prison staff of any potential threats to him.
- 9.2 Examination of prison Intelligence Records show that on the 16th July 2008 a prisoner on A wing told an Officer that he thought that Mr North may be at risk due to gang-related issues. This information was non-specific and uncorroborated. There was no indication at this time that there was any real and immediate risk to Mr North's life. Whilst the lead investigator does not dispute the likely validity of this information, it is recognised that prisoners have many different motives for passing information to both staff and other prisoners.
- 9.3 On Tuesday the 22nd July 2008 Mr North attended an afternoon session at the main prison gymnasium. This session was from 13.45 hours

through until 15.00 hours. Mr North informed the lead investigator that he recollected that this was probably his first main gym session since his return to HMP Whitemoor on the 3rd July. The only time that he had really left A wing during this period of residence was to attend a couple of supervised gym induction sessions.

9.4 Examination of the Physical Education Diary, which is completed by PE staff, shows that the afternoon session on the 22nd July consisted of both badminton and weights activities. It was attended by prisoners from A, B and C wings. This was normal practice for such sessions at that time. Mr North confirmed that he was aware that the sessions in the main gymnasium were attended by prisoners from a number of wings across the establishment.

9.5 Prison protocol dictated that mixed badminton and weights sessions were attended by a maximum of 46 prisoners. This allowed for 30 prisoners to use the cardiovascular and weights area, and 16 in the sports hall. Examination of the list of attendees at this session shows that at any one time there were between 39 and 42 prisoners in attendance. In relation to Physical Education Officers (PEOs), the agreed staffing level for these numbers of prisoners attending this particular type of session is a Senior Officer plus three Officers. Examination of the relevant records, together with interviews with the relevant PE staff, confirm that the session was supervised by PE Senior Officer (Acting) and that at any given time he was supported by between three and four Officers.

9.6 When providing an account of the events of the afternoon of the 22nd July 2008, Mr North said that it was just as the gym session was coming to an end that he was assaulted by other prisoners. He stated that he was sitting on a gym bench in the weights area near to a large wall-mounted mirror. He had just completed a particular weights set when he became aware of other prisoners in close proximity. He described them as being around him but mainly at his side. He did not pay any particular attention to these prisoners and at that point did not sense that anything was wrong or about to happen to him. At this point he pulled his T-shirt up over his face and head in order to wipe away perspiration. He described that, as his shirt was over his head, he was grabbed in a headlock and almost immediately felt a very sharp blow to the forehead. He recalled how he got pulled backwards off the gym bench and he remembered a fellow prisoner, with whom he had been training, attempting to fight off one of his attackers. He stated that it was all over very quickly but that, as he rolled over on to his knees in order to try to stand onto his feet, he was kicked in the face. His attackers then ran off to another area of the gym. From memory, Mr North could not recall his attackers saying anything to him. He described his attackers as being black and Asian. He was adamant that there were four people who attacked him, but from what he saw of them he did not recognise them as being people who he knew.

9.7 Mr North confirmed that within what appeared to be only a very short period of time the PE staff arrived on the scene of the incident. At this

point he became aware of a stream of blood coming from a wound to his head. Prison staff removed Mr North from the gymnasium and within a very short period of time he was taken to the Healthcare Centre for medical treatment.

9.8 The first member of staff to go to Mr North's assistance immediately after the assault had taken place was PEO 1. When interviewed by the lead investigator, PEO 1 stated that he could not recall how he had first become aware of the assault on Mr North. He recalled that he was on duty in the ground floor office, within the gym area, at approximately 14.50 hours when he believes that he may just have become aware of an emerging incident outside. He described how he climbed through an internal window that leads from the office immediately into the weights area. At this point he saw Mr North wandering around the cardiovascular part of the gymnasium with blood coming from his head. It appeared to him that Mr North had a friend (fellow prisoner) with him who may have tried to intervene in the attack, but he was unable to recall who that was.

9.9 PEO 1 recalled that Mr North was not particularly talkative and did not even confirm what had happened. Whilst genuine accidents do occasionally happen in the gymnasium, PEO 1 was of the clear view that Mr North had been the victim of an assault. This opinion was reinforced by the fact that on a couple of occasions Mr North attempted to pick up some dumbbells as if intent on then going to seek retribution against his attackers, and had to be prevented from doing so. PEO 1 was of the firmly-held view that Mr North knew at that point who was responsible

but would not say. Indeed, during his second interview Mr North did confirm this account by PEO 1. He stated that it was his intention to pick up the dumbbells and try to assault his attackers but was prevented from doing so by the PEOs. He also confirmed that he did have an opportunity at that time to point out the offenders, who were still located in the gym area, to the prison staff. He chose not to do so for fear of retribution. When the written transcript of this second interview was forwarded to Mr North, via his solicitor, for review and agreement he did add some additional text to the typed script. He stated that he believed it would increase the risk of violence against him if he had been seen to indicate his assailants. *“This was because of the stigma of being a grass.”* He agreed that he could have identified them at that point from their faces. He also included in his additional comments the fact that no-one asked him then who had attacked him. They (prison staff) wanted to get the area and him secure.

- 9.10 PEO 2 was one of the staff on duty in the gymnasium on the afternoon of Tuesday the 22nd July 2008. He was also quickly on the scene following the assault on Mr North. He confirms that PEO 1 was tending to Mr North when he arrived on the scene and PEO 1 indicated to him that Mr North had been attempting to pick up dumbbells as if to seek retribution. In his mind the circumstances as they appeared at that time suggested that Mr North’s injuries were not the result of an accident. He corroborated PEO 1’s account that a friend of Mr North, who was in close proximity, may have witnessed events and may have even intervened to try and minimise the severity of the attack.

- 9.11 At the time of this incident in 2008 there was no closed circuit television fitted within the gymnasium area at the prison. That has subsequently been rectified, in part due to the fact that historically there had been a number of serious 'prisoner on prisoner' assaults in that location.
- 9.12 The duty PE Senior Officer, PE Senior Officer (Acting), told the lead investigator that on the afternoon in question he was on duty in the upstairs office within the gymnasium area when he heard the alarm bell activate. The prison Control Room log records the alarm bell in the gymnasium as being activated at 14.48 hours. As would be normal practice, this prompted PE Senior Officer (Acting) to immediately make his way downstairs into the main gym area where he oversaw events until the arrival of the Orderly Officer. He could not recall in interview who that was on that day, and given the passage of time he only had a very vague recollection of events in relation to the incident involving Mr North. He stated that as per normal practice following alarm activation, it would be the clear responsibility of the Orderly Officer to take command of the incident.
- 9.13 Almost immediately after the assault had taken place, Mr North was removed from the gymnasium and taken to the prison Healthcare Centre. There he was treated by Nurse 1 and Doctor 1 at approximately 15.00 hours. He was diagnosed as having a 3 cm laceration to his forehead and a 1 cm laceration to his cheek. The Report of Injury to Inmate Form (Form F213) and Mr North's medical records show that the

laceration to the forehead was sutured by Doctor 1. The F213 also records the fact that Mr North was unwilling to state what had happened.

9.14 The lead investigator has subsequently obtained, and reviewed, a number of prison documents that relate to the assault upon Mr North in the gymnasium. These included the Physical Education Department Diary, Prison Control Room Log, Duty Managers Log, Form F213 'Report of Injury to Inmate', Orderly Officers Weekday Log and the Gymnasium Observations Book. The lead investigator also requested copies of the relevant Officers' Incident Reports; however, in the case of the latter none were available. These documents will be the subject of separate comment at various points within this report.

9.15 In addition to the points mentioned earlier, the PE Diary contains a brief entry in the section headed "Staff Observations" which relates to the alarm bell being sounded at 14.55 hours and the fact that Mr North had been assaulted in the CV (cardiovascular) area. This entry was completed by PEO 1.

9.16 As mentioned previously, the Control Room Log shows the gymnasium general alarm being activated at 14.48 hours, with the incident recorded as being resolved at 15.08 hours. It states that both Oscar 3 and Victor 1 acknowledged when notified of the alarm activation. The investigation has established that at the time of the alarm activation Victor 1 was Governor 6. It has not been possible to identify Oscar 3 although Oscar 1 was Principal Officer 3. The entry also refers to an "*attached log*",

presumably referring to a separate record of events connected to this incident. The prison has been unable to provide a copy of this record to the lead investigator and the Head of Operations at HMP Whitemoor has notified him that it is unlikely that the document can be found.

- 9.17 The duty manager's log for that day refers to an alarm bell activation in the gym at 14.55 hours. It states that Mr North was assaulted and was located in Segregation for his own protection. This was completed by the Duty Governor, Governor 6.
- 9.18 The Report of Injury to Inmate Form F213 states that during an unwitnessed incident in the fitness area, Mr North sustained a cut to his forehead. This was believed to be the result of an assault. It records the reporting Officer as PEO 1 but in the relevant section for recording details of the author of the document, the signature and date are blank. During interview PEO 1 stated, when shown the document, that despite his name being on the report he was not the author and it was not his handwriting. It was later confirmed in interview with PEO 2 that he was the author of that document.
- 9.19 The Orderly Officers Weekday Log records that at approximately 14.50 hours there was an alarm in the gym involving two prisoners fighting. It states that Mr North went to Healthcare Centre and then to Segregation. It concludes by stating that the other prisoner was not identified. It was established during interview with Principal Officer 3 that he was the duty Orderly Officer and Oscar 1 at the time of the incident and that the

aforementioned written entry in the log was in his handwriting. Principal Officer 3 could not recall attending the incident or organising any activity associated with managing it. He stated that if he had been busy on other business within the prison then Oscar 3 would have attended on his behalf, dealt with the incident and then briefed him in due course. He would then have completed the entry in the log retrospectively.

9.20 Examination of the Gym Observations Book by the lead investigator established that there was no reference to the incident involving Mr North on the 22nd July 2008. PE staff confirmed that the Observations book for the gymnasium was kept in the upstairs office where the duty Senior Officer works from. It was established that the purpose of the book is to record significant incidents and issues of general relevance to staff. It was described as, amongst other things, a staff briefing tool and a handover book. As a matter of routine any assaults are normally recorded in the book. It would appear that the normal practice was for the book to be completed by the duty SO, hence its location. That said, it is readily available to all staff to read and write in should they wish to do so. All of the PEO staff who were interviewed as a result of them being on duty at the time when Mr North was assaulted were surprised to learn that there was no reference to this incident. One described it as “*bad*”. Likewise, when informed about the absence of any entry in the Observations Book, a number of Senior Managers, including the Governing Governor at HMP Whitemoor and the Director of High Security, were both surprised and disappointed to hear of that being the case. One described it as being “*very poor*”.

9.21 Almost without exception, all staff at Whitemoor who were interviewed by the lead investigator indicated that, as per prison instructions, they would have expected everyone involved in the incident with Mr North on the 22nd July 2008 to have submitted a standard Incident Report. Junior staff were aware of what was expected of them in relation to this matter, and senior managers were quite clear that it was the role of the duty Orderly Officer to ensure that the paperwork was completed. There is no evidence to support the fact that any Incident Reports were completed on this occasion. This was subsequently endorsed in correspondence to the lead investigator from the Head of Security at HMP Whitemoor when he confirmed that the assault in the gymnasium was not recorded on the Incident Reporting System (IRS), although he stated that it “*obviously should have been*”. The absence of any incident reports has most likely resulted in there being no follow-up, no referral processes and no audit trail. PSO 1300 clearly sets out the requirement on prison staff to investigate the circumstances surrounding incidents such as this assault on Mr North. This PSO outlines the duty of the appropriate manager to investigate the incident, how the incident should be investigated, and the purpose of the investigation. There have clearly been failures at every stage in this process in relation to this incident. There is no evidence to support the fact that any investigation took place. This matter is covered further elsewhere in this report.

9.22 Whenever an alarm bell was activated across the prison, the agreed procedure was that the main prison Control Room immediately notified

both the Orderly Officer (Oscar 1) and the Duty Governor (Victor 1). That does appear to have taken place on this occasion, although it has not been able to establish with any degree of certainty why Oscar 3 and not Oscar 1 responded to the notification. It appears widely known and accepted by staff that what should have happened next is that the Duty Governor should have gone to the Control Room to take oversight of the incident and the Orderly Officer should have gone to the scene. In this particular case, again as per normal practice, the expectation would have been that the duty Senior Officer would have taken control of the incident in the gymnasium up until the arrival of the Orderly Officer.

9.23 From the information available to the lead investigator, it would appear, quite rightly, that Mr North's welfare was an immediate priority for staff on duty in the gymnasium. Mr North was quickly removed from the scene and taken to the Healthcare Centre for treatment by medical staff. What is far less clear is what, if any, importance was attached to the task of trying to identify the assailants and preserve any relevant evidence, either for a criminal or disciplinary investigation. It has not been possible to establish who took charge of the incident, what they did or what their objectives were. Mr North had clearly suffered a severe blow to his head and those responsible were still in the immediate vicinity. This presented a realistic opportunity to attempt to identify those responsible, an opportunity that was potentially lost once the prisoners returned to their respective wings. As one junior Officer stated, "*surely any blow to the head has to be seen as serious*".

9.24 The lead investigator subsequently examined a document entitled 'HMP Whitemoor Security Department – Application for Investigation by the Head of Operations'. The form contains a signature from Mr North, timed at 15.05 hours that same afternoon, 22nd July 2008, countersigned by two members of prison staff, identifying that Mr North had been spoken to by them and that he had stated that he did not require the incident to be investigated by the Head of Operations. The lead investigator was surprised to note that Mr North, whilst still in the Healthcare Treatment Room, only about ten to fifteen minutes after the attack had taken place, was being asked to make that decision. Every indication is that Mr North's signature on that document was considered to be the authority for no further action to be taken.

9.25 The previously referred to HM Prison Service and the Association of Chief Police Officers (ACPO) joint Memorandum of Understanding relates in part to the reporting to the Police of crimes that take place within prisons. Whilst this is a national document, it is clear that local interpretation and implementation will vary from prison to prison and Police Force to Police Force. The document states that:

- A decision to refer crimes to the Police should be taken at the earliest opportunity, and in any case within 24 hours.
- Regarding offences between prisoners, it is anticipated that serious offences will be reported to the Police for investigation.

- Governors are not required to report minor allegations of criminality by prisoners. These would include minor cases of assault, theft, damage, disorder and drugs offences. There is scope within the prison discipline regulations to enable these to be dealt with internally.

9.26 In the opinion of the lead investigator, based upon the facts as presented, the assault on this occasion, 22nd July 2008, would appear to be one of Grievous Bodily Harm [Wounding], contrary to Section 20 of the Offences Against the Person Act 1861. The Police Intelligence Officer at HMP Whitemoor, PC 1, confirmed with the lead investigator that he had no knowledge of the assault on Mr North on the 22nd July 2008 and that the incident had not previously been brought to his attention by prison staff. When this offence was eventually reported to the Police by Mr North, following a further serious attack on him some months later (on the 6th September 2008), this initial assault was also formally recorded and investigated. In accordance with the requirements of the Home Office National Crime Recording Standards, this first assault was recorded as an offence contrary to Section 20 of the aforementioned 1861 Act.

9.27 To greater or lesser degree, both junior and senior staff at HMP Whitemoor told the lead investigator that they believed that this assault on the 22nd July 2008 should have been reported to the Police much earlier in order for them to consider what level of investigation was appropriate. The lead investigator did establish that the previously

mentioned Memorandum of Understanding was not widely known to staff at HMP Whitemoor, including some Governor Grade managers.

9.28 What was equally unknown was the process at the prison, and who was responsible at the prison, for reporting such incidents to the Police. Some assumed that it was the responsibility of, or a combination of, the Orderly Officer, the Governor, the Security department or the Police Liaison Officer. In any event there did not appear to be an appreciation by staff of the need to act quickly to secure and preserve any evidence, identify and manage the suspects, and report incidents to the Police at the earliest opportunity.

9.29 Some Governor Grade staff spoke about previous difficulties with local Police around the Police's desire to become involved in investigating crimes that had taken place within the prison. Whilst in no way seeking to make excuses, they did consider that this may have been one factor that had influenced any decisions around referrals to the Police by staff at Whitemoor in relation to both this and some earlier unconnected incidents of assault.

9.30 Governor 1, the Governing Governor at that time at HMP Whitemoor, told the lead investigator that when he first took over command at the prison the relationship with the local Police was not as good as it might have been. He considered that, due to some of the unique challenges associated with investigating crimes in High Security Prisons, the Police were, on occasions, somewhat reluctant to get involved. He stated that

he found this quite frustrating, especially given the emerging “*gang culture*” in Whitemoor. He confirmed that he had a number of meetings with Senior Officers from Cambridgeshire Police to try to address the situation. He indicated that, whilst there was still scope for improvement, things did get better and it became accepted that if the Police Liaison Officer was not available then incidents would be phoned straight in to the Police Control Room, thus avoiding any unnecessary delays. Governor 1 was quite clear that, in his opinion, the gym attack on Mr North on the 22nd July 2008 should have been referred to the Police, irrespective of Mr North’s wishes, as the Prison Service needs to take a much more strategic view over and above the circumstances of one individual case.

- 9.31 When interviewed by the lead investigator, the Director of High Security Prisons had very clear views about this incident. He told the lead investigator that the definition of a serious assault as far as the Prison Service was concerned included any breaking of the skin and multiple bruising. He stated that there was “*no argument*” and that the assault on Mr North should have been reported to the Police. He further stated that since this incident (not necessarily because of it) things have progressed and prisons are now far more robust about reporting offences in prison to the Police. Where offences meet the criteria, there is now a policy of “*zero tolerance*”.

9.32 Local arrangements at HMP Whitemoor now appear to reflect the new approach as outlined above by the Director of High Security Prisons. One Governor with responsibility for security matters at the prison informed the lead investigator that they had tightened up procedures significantly since 2008 around how they respond to crimes by prisoners. He stated that the relationship with local Police, as a result of recent experiences, is now far better developed and professional. There is an acceptance that in certain cases, irrespective of the victim's wishes, the prison has a duty to report the offence to the Police. It is also now recognised that the prison needs to be seen to be taking action in certain circumstances. Attempts were made to reassure the lead investigator that if similar events happened now then staff on duty would immediately start considering scene-preservation and offender-identification. PC 1 confirmed that every crime that is known to have taken place in HMP Whitemoor is now referred to the Police for independent assessment at the earliest opportunity.

9.33 Putting to one side any criminal investigation by the Police, the lead investigator would, in any event, have expected an internal investigation by prison staff to have been conducted. This would not only have been from the perspective of identifying and punishing those responsible, but also to help inform the ongoing risk assessment in relation to any future threat to Mr North. It would appear clear that no such investigation took place. In this regard, it seems that not even a basic interview with the friend who had been alongside Mr North at the time of the assault in the gymnasium. Prison staff were again unclear who would be responsible

for conducting any such investigation. Some thought that it would have been a function for the Orderly Officer, some the Security department and some saw it as a function for the Safer Custody Committee. One Governor stated that, at the very least, attempts should have been made, and be seen to have been made, to identify the perpetrators of the attack.

9.34 On the 15th May 2009, Mr North was interviewed by Officers from Cambridgeshire Constabulary in connection with a far more serious attack on him by prisoners at HMP Whitemoor on the 6th September 2008. During the course of that interview, Mr North also provided details of the attack in the gymnasium earlier in the year, and asked the Police to formally investigate that incident as part of their wider investigation. In Mr North's witness statement which he made to the Police, he described the attack on him in the gym in some detail, including how he came face to face with one of his assailants. He also provided a detailed physical description of that individual and indicated that he would probably recognise him again. He told the Police that at that time he knew the attackers would be Muslim as he had previously encountered problems with individuals of that faith both at Whitemoor and elsewhere.

9.35 Mr North confirmed to the Police during that interview that when he was treated by medical staff in the Healthcare Centre a short time after the incident, he had told them that he had been injured as a result of dropping a weight on him by accident. He also stated that the next day

he told the Security Governor that he had been assaulted by another prisoner but that he didn't know who it was.

9.36 It would appear that prior to the attack on Mr North on the 22nd July 2008 there was no specific information to indicate that he was in any way vulnerable to attack by other prisoners. Mr North himself was not aware on any such threat to his safety and he has stated that he felt safe during his time on A wing. As previously mentioned, there was some non-specific, single-strand, uncorroborated information from another prisoner suggesting that Mr North may be at risk due to gang-related issues. It would appear that this type of information is common within the prison environment and that it has to be assessed and managed by staff on a daily basis. Such information, in isolation, would not be sufficient to generate any form of preventative action. All of the PE Officers and the Duty Governor on duty on the 22nd July 2008 stated that they were not aware of any intelligence, either official or prison gossip, suggesting that Mr North was particularly vulnerable at that time. In any event, it was not common practice to prevent individuals who were thought to be vulnerable from attending gym sessions. Normal practice was for the PEOs to just keep an extra eye on them. Clearly, each case was judged on its merits and the risk assessment would be informed by the credibility of the intelligence.

9.37 It would appear clear that immediately following the attack in the gymnasium Mr North had an opportunity to point out his assailant(s) to the PEOs. This is supported by his actions at that time, namely

attempting to pick up a dumbbell in order to seek retribution, his subsequent testimony to Cambridgeshire Constabulary, and the account that he provided to the lead investigator. Mr North further continued with his approach of refusing to co-operate when he told medical staff that the injuries were as a result of an accident, and when he signed the written declaration stating that he did not want the incident to be investigated by the Head of Operations. He subsequently told the lead investigator that he adopted that approach in order to try to minimise the prospect of any further attacks on him. In short, he did not want to make the situation worse. That said, it is clear that Mr North himself could, and indeed should, have done more to assist prison staff in managing the ongoing risk to his welfare.

- 9.38 Whilst the PE staff on duty in the gymnasium prevented any further escalation of the incident and took immediate action to manage Mr North's welfare, on the evidence available it would appear that very little was done at that time to preserve the scene for evidence or to make any attempt to identify those responsible. This approach appears to have continued even after the alarm bell was sounded and more senior staff were detailed to take command of the incident. From the information and records that have been made available, the Orderly Officer and Duty Governor do not appear to have taken command of the incident, despite its severity or potential for repercussions. This view is supported by both incomplete and indeed missing paperwork. It would appear that once Mr North had signed the record previously referred to, ten to fifteen

minutes after the incident, stating that he did not want an investigation, the incident was closed.

- 9.39 In support of the lead investigator's conclusions in relation to this incident, one of the HMP Whitemoor Governors who was interviewed as part of this investigation stated that they "*would have expected greater effort to try to identify perpetrators*". Likewise, the Governing Governor, Governor 1, confirmed that Mr North's lack of support for an investigation should have been disregarded and that an investigation should have taken place anyway. He also acknowledged that the record-keeping in connection with the incident was "*poor*" and should have been "*far more robust*". He described everything connected with the events of the 22nd July 2008, following the assault on Mr North, as "*regrettable*" and "*not acceptable*".

9.40 Later on this report will outline the circumstances of a much more serious assault on Mr North on C wing at the prison on the 6th September 2008. It will never be possible to establish with any degree of certainty whether that incident would have happened if Mr North himself had been more co-operative with prison staff and worked with them to identify the offenders and manage the risk to himself, or if prison staff had made greater effort to secure evidence, attempt to identify offenders, conduct an internal investigation and refer the matter to the Police.

KEY FINDING 6. Immediately following the attack in the gymnasium on the 22nd July 2008, Mr North clearly had an opportunity, had he wished to do so, to identify his attackers to the Physical Education Officers. It can be argued that Mr North could, and indeed should, have done more himself to assist prison staff in managing the ongoing risk to his welfare. Mr North made the task of those charged with managing any ongoing risk even more challenging by initially informing them that he had suffered an accident, and then refusing to support an internal investigation.

KEY FINDING 7. The PE staff on duty in the gymnasium at the time of the assault on Mr North, whilst preventing an escalation of any disorder, and

properly managing Mr North's welfare, appear to have done very little to secure and preserve any evidence or identify the persons responsible. In addition, neither the Duty Governor nor the Orderly Officer appears to have taken command of the incident, beyond segregating Mr North, despite its severity and the potential for repercussions. There was no internal investigation conducted in accordance with PSO 1300 and the assault was not reported to the Police, as per national guidance, for criminal investigation.

RECOMMENDATION 1. If it has not already done so, HMP Whitemoor may wish to consider the benefits to be obtained from reviewing internal procedures and guidance for the management, recording and investigation under PSOs 1300, 2700 and 2750 of both prisoner on prisoner assaults and unexplained injuries. It may also be considered appropriate to reinforce any guidance with staff at the establishment in order to ensure an appropriate level of compliance.

RECOMMENDATION 2. If they have not already done so, NOMS and HMP Whitemoor should consider if current

procedures and staff training provide for the full and accurate completion of official prison documents. Adequate audit and storage arrangements should also be considered as part of any subsequent review. The investigation highlighted a high number of either incomplete, or missing, official prison records. HMP Whitemoor should consider the policy on retaining both draft and final copies of letters and ensure that a process is in place to readily differentiate between draft and final versions of documents.

RECOMMENDATION 3. If it has not already done so, NOMS should consider the requirement, and benefits to be gained, by reviewing how it responds to managing serious prisoner on prisoner assaults or indeed other critical incidents. Whilst not necessarily exclusive, this review should consider including issues such as command structure, scene and evidence preservation, offender identification and management, plus timely investigations and referral to the Police. There should be absolute clarity at any given time as to who is in command of the prison should a critical incident arise.

RECOMMENDATION 4. If it has not already done so, NOMS should consider the requirement to review, at both national and local levels, protocols and procedures for referring crimes that take place within prisons to the Police, so that all organisations are clear around what is expected of them and the service that will be provided in return.

CHAPTER 10.

PERIOD IN SEGREGATION – 22ND JULY 2008 TO 6TH SEPTEMBER 2008

- 10.1 Prison Service Order (PSO) 1700 outlined the Policy and Procedure in relation to the segregation of prisoners. It stated that “*a decision to segregate a prisoner is taken by a competent operational manager, having regard to the individual circumstances of the prisoner concerned. The safety of the prisoner whilst in segregation is of paramount importance*”. It is a requirement that an Initial Segregation Safety Screen is completed for all prisoners placed in the Segregation Unit and before an award of cellular confinement is given. In addition, the Healthcare Centre should be informed that a prisoner is in Segregation within 30 minutes of being located in the unit. The Initial Segregation Safety Screen should be completed within two hours.
- 10.2 Prison Rule 45 allows for the segregation of prisoners for reasons of both Good Order and Discipline and for their Own Protection. The period of initial segregation, without a review board, is for a maximum of 72 hours. All prisoners who are to remain in segregation must have a Segregation History Sheet opened and this must be kept up-to-date.

- 10.3 Prisoners segregated under Prison Rule 45 must be told the reasons why they are being held in the Segregation Unit. This should be done orally and in writing. In addition, the prisoner should be told when the first review of their segregation will take place and whether or not they will have the opportunity to attend this meeting. Subsequent Review Boards should be held at a frequency to be agreed locally but, in any event, at least every 14 days, and should be chaired by an operational manager.
- 10.4 This Prison Service Order outlines how the desired outcome for any prisoner located within the Segregation Unit is to enable their return to normal location as soon as the Segregation Review Board feels that it is appropriate and safe for themselves, staff and other prisoners to do so. It also imposes an obligation on review boards to facilitate the transfer of a prisoner to another establishment if it is no longer appropriate for the prisoner to remain in the current one.
- 10.5 The document also provides guidance to staff in relation to points to consider before authorising segregation under Rule 45 for their own protection. It states that “*The Prison Service, the Governor, Director and all members of staff concerned owe a duty to the prisoner to take ‘reasonable care in the circumstances’ to protect him or her from injury.*” It goes on to clarify that staff are liable in law for damages if they fail to take all reasonable precautions to prevent an attack on a prisoner by another prisoner or prisoners, and that this duty is reinforced by Article 2 of the European Convention on Human Rights. It further defines

reasonable care in the circumstances and states that “*prison managers will have to exercise their judgement as to the nature and extent of the threat and not simply accept that the posing of a threat is sufficient in itself to justify the use of Rule 45*”.

10.6 Following Mr North’s assault in the prison gymnasium at around 14.50 hours on Tuesday the 22nd July 2008, Mr North was seen at approximately 16.15 hours in the Healthcare Centre by Governor 6. Governor 6 was Victor 1 and Duty Governor at that time. Governor 6 informed the lead investigator in interview that during the period between him being made aware of the attack on Mr North and meeting with him in Healthcare a short time later, he had requested and received, an intelligence briefing from the Security department. This was to enable him to make an informed decision around the requirement, or otherwise, to segregate Mr North under Rule 45. Based upon the information received, Governor 6 made the decision that it was in Mr North’s best interests to segregate him for his own protection in order to allow a proper investigation and risk assessment to be carried out. He could not recall the content of the intelligence briefing when interviewed; suffice to say it was clear to him that a return to the wing at that time would not have been appropriate. The relevant paperwork was then completed, including the Initial Segregation Safety Assessment by the Healthcare nurse. Records show this having been carried out at 16.20 hours.

10.7 Governor 6 made it clear to Mr North, and recorded in writing, that he was being segregated at that time as there was “*Intelligence to suggest*

you remain under threat from other prisoners". Governor 6 has stated that Mr North did not take this decision too well. Governor 6's response was robust but also calm. He made it clear to Mr North that he was not going back to the wing, even though he appeared to have convinced himself that he was.

- 10.8 During the course of this investigation, the lead investigator attempted to quality assure the initial decision of Governor 6 to authorise segregation under Rule 45 for Mr North's own protection. Without exception, other managers at the prison endorsed his approach at that time and indicated that they would have made the same decision in those circumstances. Following his initial segregation, Mr North remained located within that unit until Saturday the 6th September 2008.
- 10.9 Mr North told the lead investigator that almost immediately after his segregation on this occasion he tasked a fellow prisoner in the unit with informing Legal Practice 1 of his latest transfer away from main location. It would appear that the prisoner concerned also used that firm of solicitors to represent his interests and he already had a telephone call to their office booked. This resulted in the prison receiving a faxed letter from Legal Practice 1 during the course of the 23rd July. The content and tone of this letter could best be described as direct and challenging. Whilst allowing for messages becoming distorted whilst in transit, it suggested that no explanation had been provided to their client around his reasons for segregation and he had not been placed on report for breach of Prison Rules. It stated that in light of recent events involving

Mr North, they *“take the situation very seriously”*. This was the first of a number of letters from Legal Practice 1 to HMP Whitemoor over the course of the next few weeks. These will be referred to in greater detail elsewhere in this report.

10.10 The following day, the 24th July 2008, Senior Officer 3 from the Segregation Unit at the prison sent a letter of reply to Legal Practice 1 explaining that their client was in fact now located within the Segregation Unit as he *“remains under threat from other prisoners”*.

10.11 Also on the 24th July 2008, and in accordance with the requirements of PSO 1700, Mr North attended his first Segregation Review Board. This was chaired by Governor 5. A Segregation Review Board Governors’ Report was completed and this record shows that continued segregation was authorised through until the 29th July 2008 and that Mr North was being considered for a transfer to another establishment. That said, later in the document that is amended to *“maybe”*, depending upon the security risk assessment. It also states that Mr North was unhappy at being in the Segregation Unit. During interview, Governor 5 told investigators that from memory she could not recall if a move away from Whitemoor was already being progressed or if it was her intention to instigate one.

10.12 Mr North appeared before his next Segregation Review Board on the 29th July 2008. Again the Board was chaired by Governor 5. Mr North made representations that he wished to return to the wing, but his

continued segregation was authorised until the 12th August 2008. On this occasion Governor 5 endorsed the Governors' Report to the effect that Mr North at this time was not being considered for a transfer to another prison. She also made an entry on the report stating, "*Mr North in segregation on OP against his wishes following a serious assault on him. Governor 4 is investigating matter and advised that his enquiries will be completed in next couple of days. Decision will then be made whether safe to return to wing*". Amongst others, the Review Board was attended by IMB 1, a member of the prison Independent Monitoring Board (IMB).

10.13 An extract from the 'Dictionary of Prisons & Punishments', edited by Yvonne Jewkes and Jamie Bennett, defines Independent Monitoring Boards (IMBs) as follows:

"Independent Monitoring Boards are groups of lay people, appointed by the Home Secretary, with the statutory role of monitoring the fairness and decency of the treatment of prisoners."

10.14 By law, every prison establishment across England and Wales must have an Independent Monitoring Board. Generally, they comprise between 12 and 20 members of the local community who are appointed to a specific prison for a period of three years. These appointments are renewable for further periods of three years at a time.

10.15 Generally, Board members have unrestricted access to the prison, subject only to appropriate security considerations. The IMB must be notified promptly by the Governor of the relevant establishment of any serious incident so that they may attend in order to monitor the situation.

10.16 It is worth recording at this point that IMB 1, in his capacity of IMB member, attended all of the subsequent Segregation Review Boards that we considered as part of this investigation. Records indicate that IMB 1 consistently endorsed the decision of the Review Panel Chair. Unfortunately, it was not possible for investigators to obtain an account of events from him as he had sadly passed away in the interim.

10.17 Governor 5 informed the lead investigator that at the time of this Review Board, namely the 29th July 2008, she believed that Governor 4, Head of Dynamic Security, was still conducting the investigation into the level of threat posed to Mr North, however by that time she was aware that he was considering the prospect of returning Mr North to main location at Whitemoor. The investigation being conducted by Governor 4 might better be described as a risk assessment. He was not conducting an investigation into the circumstances around the assault on Mr North that had taken place on the 22nd July 2008. Governor 4 himself described at interview that what he was doing was a risk assessment, using current intelligence, to see if it was considered safe for Mr North to return to the wing.

10.18 On the 29th July 2008, exactly one week after his initial segregation, Mr North sent a handwritten note to Legal Practice 1. In his note Mr North stated that he had an accident in the gym and he had not been assaulted as the Governor thought. He clarified that he wanted to go back onto the wing. During interview with the lead investigator Mr North agreed that this account was less than honest about his situation and the reasons for his segregation. Via his current solicitor, he has stated that his main concern was to get out of segregation and if he had said he had been assaulted that could give them (prison staff) reason to keep him there.

10.19 This resulted in Legal Practice 1 sending a faxed letter, also dated the 29th July, to HMP Whitemoor. Again, the tone and content of the letter can best be described as direct and challenging. It quoted Prison Rule 45 and outlined the legal obligations on the prison when authorising segregation for reasons of good order and discipline. It stated that their client did not accept the reasons for segregation and it requested a response within 48 hours if a return to the wing was not imminent. It would not appear that any consideration was being given by Legal Practice 1 to the issue of whether or not Mr North was indeed at risk; nor did it seem to recognise the right of the prison to segregate under Prison Rule 45 for reasons of Own Protection. Solicitor 1, solicitor and Principal of Legal Practice 1, stated during interview with the lead investigator that in his opinion he didn't consider this letter to be "*waving a big stick*" at that time. He described it as fairly neutral and just asking for more information. He did however confirm that, because of Mr North's

instructions, they were “*sceptical*” as to whether or not Mr North had been assaulted, especially given his history and how he had been managed in other prisons. Solicitor 1 stated that he saw security information as an easy way of justifying a course of action as it will usually be the type of information that cannot be given out!

10.20 On the 31st July 2008 Senior Officer 3 sent a letter to Legal Practice 1 in response to theirs of the 29th July 2008. In his letter Senior Officer 3 reinforced the fact that Mr North was in segregation for his own protection due to him having been assaulted and that intelligence existed suggesting that he remained under threat from other prisoners. It confirmed the date of Mr North’s next Review Board as the 12th August. Senior Officer 3 also stated that Mr North was not co-operating with the Security Manager at the present time and consequently that he was to remain in the Segregation Unit until it could be established that it would be safe for him to return to normal location.

10.21 It transpired during interview with Solicitor 1 that his version of the letter sent by Senior Officer 3 on 31st July 2008 was slightly different to the one in possession of the lead investigator. Upon closer examination, Solicitor 1’s copy did not contain details of the Rule under which Mr North was being held. Neither did it include the fact that he was not co-operating with the Security Manager. Clearly, it was not helpful to any of the parties to find that two different versions of the same correspondence existed. It cannot be judged whether the absence of the missing information on Solicitor 1’s copy of this letter shaped the

future correspondence that was sent to the prison. Further examples of multiple versions of other documents (primarily letters written by staff at HMP Whitemoor) arose during the course of the investigation. This may be an issue that the prison would wish to avoid in the future.

10.22 Mr North next attended a Segregation Review Board on the 12th August 2008. Again, the Board was chaired by Governor 5 and was also attended by IMB 1 from the IMB. Mr North was again signed on to remain segregated for a further 14 days until the 26th August. This decision was again endorsed by the IMB. On this occasion Governor 5 endorsed the record, stating that Mr North was being considered for a transfer to another establishment as there was a significant risk to his safety at Whitemoor. As if to clarify this point, she also wrote "*Population Management to arrange transfer*". Governor 5 told the lead investigator that she assumes that she would have endorsed the record to that effect due to the fact that Governor 4 had completed his investigation and it had been decided that it was necessary to move Mr North to another prison.

- 10.23 Further to this Segregation Review Board, on a separate IMB file note, IMB 1 recorded the fact that Mr North again requested a return to the wing. He stated that Governor 4 was looking into it and Population Management was not looking for transfer at present. Whilst this is at odds with the Governors' Record, it is assumed that this is simply due to a misunderstanding or error in recording and that it is of no particular significance to future events.
- 10.24 On the 19th August 2008, Mr North again wrote to Legal Practice 1. On this occasion he asked them to pursue an alternative to segregation as he had done nothing to warrant his ongoing detention within that unit.
- 10.25 Mr North's final Segregation Review Board was held on the 26th August 2008. Once again, the meeting was chaired by Governor 5. The IMB was again represented by IMB 1. The decision was again made to keep Mr North in the Segregation Unit for reason of his own protection. As previously, this decision was supported by the IMB and the Governors' Report endorsed the decision accordingly. On this occasion, Governor 5 recorded the fact that Mr North was being considered for transfer to another establishment as Security considered his safety to be at risk on normal location. She again stated that Population Management were to chase up a transfer. The date for Mr North's next Review Board was set for the 9th September 2008.
- 10.26 On the 26th August 2008 Legal practitioner 1 of Legal Practice 1 telefaxed a copy of a letter before claim for Judicial Review to NOMS

Headquarters, addressed to the Secretary of State for Justice. This sought to challenge the decision to keep Mr North in Segregation under Prison Rule 45 for Good Order and Discipline / In the Prisoner's Own Interests. The letter set out the grounds for the claim and recorded the fact that Mr North refuted the fact that there was a threat to his safety on the main wing at Whitemoor and any threat that was posed was clearly not sufficient to justify the continued use of segregation under Rule 45. The letter also referred to the fact that Mr North had spent almost the entire last five months in Segregation, given that he was in the Segregation Unit at HMP Full Sutton for a period of over three months immediately prior to his transfer to Whitemoor. Understandably, the letter raised significant concerns that such a period of segregation was having a negative impact upon Mr North's physical and mental wellbeing. It also set out what action was expected of NOMS in order to address Mr North's concerns. These actions are listed as:

- *“Either remove Mr North from the Segregation Unit and return him to the main wing at HMP Whitemoor; OR*
- *Remove Mr North from the Segregation Unit and transfer him to a different prison, by no later than 5 pm on 29th August 2008.”*

10.27 On the 29th August 2008, Governor 4 replied by letter to Legal Practice 1 in respect of the aforementioned letter before claim. In his letter, Governor 4 stated that the information currently available indicated that the recent assault took place as a result of an incident approximately one year previously in which Mr North was fighting with another prisoner. In addition, intelligence indicated that there was an ongoing feud between Mr North and other prisoners as a result of these two incidents. Due to this, the decision to segregate Mr North was made to ensure his safety was maintained as well as that of other prisoners and staff. Governor 4 outlined how he had personally spoken with Mr North on two occasions and explained this to him. Mr North initially denied that any assault had taken place and indicated that he had no idea why he was being segregated. On the second occasion he did admit that there was an incident and this was related to the fight a year previously. However, Mr North continued to suggest that this was now all over and that there would be no further incidents. Mr North was asked to provide the names of the other prisoners involved as the prison needed these facts in order to make decisions based on all available information. His unwillingness to provide this information provided no evidence to support his statement that the matter was resolved.

10.28 The same letter also recorded how a decision was made to return Mr North to the wings on the 27th August, but further information was received on that day stating that the feud was not over and that there would be further acts of indiscipline if he returned to the wing. For these reasons, he remained segregated. The letter went on to state that attempts to transfer Mr North to another High Security Prison had been made but due to his custodial record no other establishment was willing to take him. Further attempts at transfer were continuing. A copy of this letter was sent, under Rule 39, to Mr North by Legal Practice 1 on the 1st September 2008, inviting his comments and further instructions. Also, on the 1st September 2008 the Briefing and Casework Unit at NOMS wrote to the Governor at HMP Whitemoor requesting information about Mr North's ongoing segregation in light of an impending Judicial Review. This letter and the subsequent response from Principal Officer 1 dated the 8th September 2008 have been examined by the lead investigator and they contain no information to suggest this correspondence has in any way influenced or impacted upon the decision to return Mr North to main location from the Segregation Unit.

- 10.29 Solicitor 1 informed the lead investigator that he considered the aforementioned letter from Governor 4 to be helpful and far more detailed than one might normally expect. He was of the opinion, in light of this information, that without a considerable amount of additional work being carried out, there was potentially little prospect of them succeeding with the Judicial Review claim at that point.
- 10.30 During his initial interview with the lead investigator Mr North outlined how, on or around the 28th August 2008, he was informed by an Officer in the Segregation Unit that he was going to be returning to the main wings at Whitemoor. Mr North stated that he was told he was going to A wing and consequently he had his bags packed in preparation, but, later that same evening he was informed that he was not now returning as planned as there was new information indicating that he was still at risk.
- 10.31 In relation to the above, the lead investigator has examined an SIR dated the 27th August 2008. This outlines that on this date, whilst Mr North's previous cell on A wing was being prepared for his return, a prisoner on the wing asked if Mr North was coming back. When the reporting Officer indicated that was the intention, the prisoner suggested that, should that happen, "*things would kick off*". As a consequence, the decision to return Mr North to A wing from segregation at that time was abandoned in order for a further risk assessment to be carried out, and to allow time for any additional corroborating intelligence to be gathered and assessed.

- 10.32 On the 5th September 2008 Mr North telephoned Legal Practice 1 and left a message for Legal Practitioner 1. A handwritten note from his file [author unknown] states that Mr North had received the prison's response [Governor 4's letter of the 29th August] and doesn't agree with it. *"No fight / feud is taking place, just an excuse to keep him down there. He is happy to be on main wing, not frightened for his safety. Fight last year- was nicked for it at time. Didn't say a name as incident is sorted and over"*.
- 10.33 Later that same day, 5th September 2008, Legal Practice 1 sent a 'Rule 39' letter to Mr North stating that they had again written to the Head of Dynamic Security at HMP Whitemoor informing him that their explanation for his continued segregation was unsatisfactory. The letter clarified that Judicial Review proceedings may well follow unless he was transferred or returned to the main wings by Tuesday the 9th September at 4 pm. It concludes, *"Unlike your previous claim against segregation, the merits of this case are not so clear. It would be helpful for you to write to us with as much detail as possible in regard the truth as to the so called feud"*. A copy of the letter sent to the Head of Dynamic Security was also supplied to Mr North.
- 10.34 The aforementioned letter of the 5th September 2008 to Governor 4 stated that the explanation provided to Mr North in relation to his ongoing segregation was unsatisfactory. Legal Practice 1 outlined that it was difficult to accept that an incident that occurred over a year ago could

possibly form the basis of Mr North's current segregation. They stated that they did not accept the logic behind the conclusions reached, and Mr North's refusal to provide the names of other prisoners involved was no indication that the matter had not been resolved and consequently remained ongoing. They expressed a view that if Mr North had revealed names it would possibly have resulted in an extension of the feud, and that he was quite entitled to refuse this information. In relation to the decision made on or around the 27th August not to subsequently return Mr North to the wing the letter stated, "*We seriously question whether you received any new information of the so called feud. We wonder instead if the real reason is related to the further acts of indiscipline that you refer to in your letter*". It continued, "*We are driven to conclude that the real reason for Mr North's continued segregation is continued punishment for incidents of so called indiscipline that occurred at HMP Full Sutton*". Legal Practice 1 also requested that HMP Whitemoor supply copies of exchanges between themselves and other establishments in order to confirm that Mr North was unable to be placed elsewhere. The letter concluded by stating that Judicial Review proceedings would continue unless they heard that Mr North had moved prisons or been returned to location on the main wings by Tuesday the 9th September 2008. As per normal practice the letter was signed simply "*Legal Practice 1*".

- 10.35 During interview with Solicitor 1, the lead investigator spoke at some length about the correspondence between his firm and HMP Whitemoor, in particular around the tone and content of the letter sent to the Head of

Dynamic Security on the 5th September 2008. Solicitor 1 appeared to have some concerns around the content of the letter, stating, "*I'm not particularly happy reading that letter now*". He implied that the letter had been written by Legal practitioner 1, his legal caseworker, and not by him. He actually thought that it was likely that he was not in the office on the day that this correspondence was sent. He did however confirm that they thought that the prison was "*playing games*".

10.36 As part of this investigation, the lead investigator carried out a detailed review of all of the intelligence held by HMP Whitemoor, in particular any that was held prior to Mr North's return to C wing on the 6th September 2008. Post his assault on the 22nd July and during his period in segregation there was a small amount of prisoner-generated information. This was very non-specific and in the main related to the nature of the attack on Mr North in the gymnasium, as opposed to identifying those who were responsible, or the likely future risk. There was intelligence to suggest that the matter was not resolved and had the potential to continue into the future. Whilst indicating that Mr North might be at risk, it did not in any way identify where (who) that risk was likely to come from over and above Muslim prisoners – which was something that Mr North was himself aware of.

10.37 The lead investigator also interviewed a number of staff at HMP Whitemoor who were involved in the management of prison intelligence. The widely-held view was that there was some intelligence to support the hypothesis that Mr North was at risk from further attack but that

because of his transfer to the Segregation Unit that information, to a degree, had dried up. The Deputy Head of Security, Governor 7, stated that in his opinion there was a generally-held view that Mr North was vulnerable if he returned to main location; however there was not a huge amount of tangible evidence or intelligence to support that opinion. Governor 4 stated in interview that there was no specific intelligence that Mr North was really at any greater risk than that faced by most other prisoners in HMP Whitemoor, or any different to that which he had lived with for all of his prison life.

- 10.38 Governor 4 confirmed that he had personally spoken with Mr North on a number of occasions whilst he was in the Segregation Unit between the 22nd July and the 6th September 2008. He agreed that he did ask him to name, or at least help in identifying, those individuals who had attacked him in the gymnasium. It was felt that this information would help inform any risk assessment, and subsequent decision around keeping him in the Segregation Unit, returning him to main location at HMP Whitemoor, or securing his transfer to another prison. Mr North continually refused to provide any information to assist with this process.
- 10.39 When interviewed by the lead investigator in connection with his time on Segregation Unit, Mr North stated that a fellow prisoner who arrived in the Segregation Unit at some point told him that he had been to Friday service and the reason he (Mr North) had been assaulted in the gym was due to the fact that he had allegedly assaulted another prisoner some time previously whilst he was washing for Friday prayers. Mr North also confirmed that he had been told that he had actually been hit with an iron bar and that one of his attackers was named Prisoner 1. Prisoner 3 had also been mentioned but Mr North didn't know if that was the prisoner's proper name. He said that the name(s) mentioned were certainly "*Asian-type names*".
- 10.40 Mr North confirmed that he never passed this information about his assailants on to the staff at HMP Whitemoor. He believed that to do so would most likely lead to further assaults on him in due course, and he considered that Security would already be aware of this information. He

wrongly believed that “*they knew everything within days of an incident*”. When pressed, he did not accept that he had any obligation to inform Security of the possible identity of his attackers, and had no perception that this may have assisted them in managing the risk against him.

- 10.41 When the written transcript of his second interview was forwarded to Mr North, via his solicitor, for review and agreement Mr North added some further text in connection with this issue. He stated that he learned the names after the second assault. This is at odds with what he had actually said during formal interview with the lead investigator. Originally he was very clear that he had become aware of two names whilst in segregation following that assault in the gymnasium on the 22nd July 2008, but prior to his relocation on C wing on the 6th September 2008.

- 10.42 Mr North provided the lead investigator with the name of his fellow prisoner who had informed him of the identities of his assailants in the gymnasium on the 22nd July 2008. Subsequent enquiries with NOMS have failed to identify an exact match on the name provide by Mr North. It is believed that the forename supplied by Mr North may well be a nickname. As a result of additional information made available to the lead investigator, it would appear probably that the individual to whom Mr North is referring has been positively identified as Prisoner 4. The lead investigator, by prior appointment, visited HMP Peterborough in September 2011 in order to interview Prisoner 4 in connection with this matter. Despite Prisoner 4 initially agreeing to be interviewed, he subsequently withdrew his consent upon the arrival of the lead investigator at the prison. The interview has never taken place.
- 10.43 In an attempt to clarify Mr North's accounts in relation to who told him about the identities of his assailants in the gymnasium and when, the lead investigator has examined the core Prison Record of Prisoner 4. The F2052A (Prisoner History Sheets) for the period July through until September 2008 are not contained within these records. It has therefore not been possible to establish if Mr North and Prisoner 4 were both located with the Segregation Unit at any time between 22nd July 2008 and the 6th September 2008.
- 10.44 The F2052A for Prisoner 4 records that he was in the Healthcare Centre on the 3rd December 2008. This is confirmed by the fact that there are complaint forms submitted by Prisoner 4 on both 5th and 8th December

2008. Mr North was located in the same Healthcare Centre from 2nd December 2008 until 17th December 2008. There is no mention of Mr North in Prisoner 4's F2050A History Sheets that are on file for this period of time.

10.45 To summarise, enquiries have not been able to establish with any degree of certainty which of Mr North's two different accounts of events is correct. There is no information available to indicate if they were both located in the Segregation Unit during the relevant period or not. Evidence does exist to show that both were located in the Healthcare Centre at HMP Whitemoor on a number of days during early December 2008.

10.46 In the opinion of the lead investigator, irrespective of when Mr North was given this particular information and by whom, the fact remains that over a protracted period of time and on a number of occasions Mr North chose to withhold information, pass on inaccurate information and generally failed to cooperate with prison staff who were responsible for managing any potential ongoing risks to his safety and general welfare. In addition, he had the opportunity and ability to make a visual identification of his attackers to prison staff in the gymnasium on 22nd July 2008 immediately after the assault.

10.47 Mr North stated to the lead investigator that whilst in the Segregation Unit, due to the nature of the regime, he had no real understanding of any potential threat that remained against him. He thought that if he was

at risk then he might know what group of prisoners the risk was likely to come from, namely Muslims, but he did not know which individuals. He confirmed that it was common in prison culture for any attacks to be carried out by people other than the specific person with whom you had a disagreement. Consequently, you always needed to be looking over your shoulder. This concurs with views expressed by others as part of this investigation.

- 10.48 Mr North confirmed that during his period in the Segregation Unit he wanted to return to A wing because he had felt safe there previously. He clearly felt that his confinement to the Segregation Unit was a punishment, even possibly a continuation of the treatment that he had received at HMP Full Sutton prior to his transfer to Whitemoor. He considered that the threat against him was being exaggerated and being used as a reason to keep him segregated. He had no concept of any serious threat to him, or the fact that the prison might just be acting in his own interests, something that he grudgingly accepted as a possibility in a later interview.

- 10.49 It is clear that during his period in the Segregation Unit, for all of the reasons outlined previously, Mr North seized any opportunity available to him to make staff aware of his desire to return to A wing and to reinforce his opinion that there was no ongoing threat to his personal safety.
- 10.50 Under existing arrangements, all prisoners in the Segregation Unit were seen on a daily basis by an Operational Manager. In HMP Whitemoor's case this was generally the Duty Governor. The Governing Governor, Governor 1, stated that this was to ensure that prisoners were being cared for in accordance with Prison Service Orders and that their general level of wellbeing was proportionate. It also provided prisoners with an opportunity to raise issues of concern at an appropriate level. Any issues of significance would be managed and progressed by the Duty Governor and a written record would be made on both the Prisoners Personal Record, and the Segregation Observations Book. In the case of the latter, HMP Whitemoor were unable to furnish the lead investigator with a copy of the Segregation Unit Observation Books for the period from the 22nd July 2008 until the 6th September 2008. The Deputy Head of Security notified the lead investigator by letter that an extensive search had been made, without success, and that it was now unlikely that the records could be found.
- 10.51 The Prisoners Personal Record relating to Mr North, together with the Duty Governor's Diary Records relating to daily Governors' Rounds, show that on numerous occasions during his period in the Segregation

Unit Mr North had requested, at times almost demanded, a return to main location. On some occasions A wing has been specifically mentioned. When interviewed by the lead investigator, the Governors who had seen Mr North during the aforementioned daily rounds were of the view that at that time he did not appear to have any concerns in relation to a threat to his personal safety. An Officer who looked after Mr North during his period of segregation stated that Mr North liked to create an impression that nothing fazed him.

10.52 PSO 1700 placed a requirement on IMB members to visit the Segregation Unit and to speak to both staff and prisoners. This requirement also included the provision of a facility for prisoners to speak to members in confidence whenever possible and safe to do so. The Order also stated that such visits should be recorded in the Segregation Unit Daily Diary Sheets.

10.53 As part of this investigation HMP Whitemoor was asked to make these documents available for examination. A letter was received from Governor 7, dated the 5th October 2010, stating that the Segregation Unit documents for the relevant dates could not be found. These are just some of the many documents that the prison has not been in a position to furnish to the lead investigator as part of this Article 2 investigation.

10.54 PSO 1700 places an obligation on Segregation Review Boards to consider and facilitate transfers to other prison establishments where such a move is deemed necessary. It is clear that at some, if indeed not

all, of the Segregation Review Boards for Mr North consideration was being given to transferring him to another establishment. The lead investigator obtained a copy of the Directorate of High Security Prisons (DHSP) – Pre Transfer from Segregation Form in relation to Mr North. This document contained no name or signature for the author, no date of completion, nor the names of the other establishments that had been approached to take him. There was a reply attached from HMP Wakefield, dated the 3rd September 2008, refusing to accept Mr North as they were not equipped to deliver the offender development courses that he needed. There was also a reply from HMP Full Sutton, again dated the 3rd September 2008, refusing to take him on the basis that they transferred him to Whitemoor on the 3rd July 2008 for reasons of good order and discipline.

10.55 Governor 4 confirmed to the lead investigator that moving Mr North via Population Management was a challenge as, in his opinion, everyone knew him and nobody would volunteer to take him. This was not necessarily because of his overt behaviour on the wings as he was actually quite easy to deal with for the landing staff; it was the undercurrent of criminality that came with him that represented the challenge.

10.56 The lead investigator subsequently interviewed the two members of staff from the Population Management Office at HMP Whitemoor, Officer 2 and Officer 3. It was established that the process for requesting a transfer was as follows: a transfer request could come into Population

Management from any Governor at the establishment but normally via the Security Governor. The request was not always in writing; it could be a verbal request. Indeed, it was suggested that a verbal approach was common. The Directorate of High Security Prisons (DHSP) Form was then raised by Population Management and subsequently telefaxed to the other High Security Prisons. Following informal dialogue between Population Management staff at the respective prisons, once a transfer had been agreed, the form would be signed in due course by a Governor Grade member of staff at both the transferring and receiving establishments. Once it was all agreed at that level, the Director of High Security would have to endorse the move. It was established that there was an escalation process to be followed when a prisoner had to be relocated but no establishment was willing to take them on a voluntary basis. Firstly, the Security Governor or Head of Operations would speak to their counterparts in the other establishments. If that proved unsuccessful then there would be similar dialogue from Deputy Governor to Deputy Governor. Ultimately, if stalemate prevailed then the Director of High Security at NOMS Headquarters could order a prison to take a transferee if necessary. In this case there was no evidence to support the fact that the escalation process had been given any consideration.

- 10.57 The Deputy Security Governor at HMP Whitemoor, Governor 7, described this process as very frustrating and something that is being addressed at NOMS Headquarters. The intention is that they become something akin to an independent broker, almost a clearing house, for

movements of Category A prisoners. He stated that historically, in his personal experience, he had never known the Category A Section at HQ to impose a prisoner on any establishment. He concluded that in 2008 it was very hard to move someone.

10.58 Governor 1 told the lead investigator that in his then current capacity as Head of High Security Prisons Group he now chaired a monthly High Security Population Management Steering Group. This arrangement was not in place at the time of this case in 2008. Governor 1 confirmed that historically it was very rare that Directors would intervene in relation to prisoner transfers. He described the new arrangements as far more holistic. Via this process he now made national decisions based upon the best available information about who needed to go where, albeit that the starting point remains that establishments should attempt to try and consume their own smoke and manage prisoners out of Segregation Units prior to trying to seek a transfer for them.

10.59 Returning to Mr North's case, further dialogue with Officer 2 and Officer 3 failed to fill any of the missing gaps in relation to such matters as to 'Which other High Security Prisons were asked to take Mr North and when?', 'How were any requests to other prisons made and by whom?' and "What, if any, responses were received from other prisons and when?" The lead investigator subsequently received a note from Officer 2 stating that there are no further records within the Population Management office relating to this particular case. The lead investigator

would have expected to have found additional documents to support any further enquiries with other prisons had they taken place.

10.60 Every indication suggests that Mr North was rightly segregated on the 22nd July 2008 under Rule 45 for reasons of his own protection. PSO 1700 which outlines the policy and procedure in relation to segregation was correctly followed throughout the whole period from initial sign-on right through until his transfer to C wing on the 6th September 2008. This includes his appearance before, and the management of, his Segregation Review Boards. That said, the one area that does remain unclear is what was done, by whom and when, to try and facilitate a transfer out of HMP Whitemoor to another high security establishment. The Segregation Review Boards Governors' Reports suggest that this was an option that was being progressed. The incomplete DHSP documents relating to transfer, together with the information provided during interviews with the Population Management staff, leave many gaps in the information required and do not add any clarity to this matter. It leaves the question hanging as to whether the prison did all that it could to relocate Mr North to another establishment, thus minimising the amount of time that he needed to spend in segregation. Again, the matter of records management may be an area that the prison would wish to address if it has not already done so.

- 10.61 The lead investigator was encouraged by the existence of the new Population Management Steering Group (now called Population Management Meeting) to which Governor 1 referred during interview. This would appear to manage, at an appropriately senior level, the type of challenge faced by Whitemoor in August/September 2008.
- 10.62 It is clear that, on the face of it at least, Mr North was totally blasé in relation to the level of threat and risk that he potentially faced from other prisoners. His frequent protestations to prison staff and his demands to return to main location over a protracted period of time endorse this fact. Whilst attempting to take account of the environment in which a Category A prisoner is located, and trying to understand the impact of his naming his assailants to prison staff, it is apparent that he could, and indeed should, have done more to work with Security staff to identify and manage down any ongoing risk to his safety. This would include him passing on details of the identities of his attackers once that information was in his possession. That would have enabled the prison to make far better-informed decisions about what was best for him. Equally, it is clear that Mr North chose to totally mislead his legal representatives at Legal Practice 1, maintaining for some time the story that no assault on him had taken place. Consequently, it could be argued that they were not able to best represent his interests during his period of segregation.
- 10.63 The Terms of Reference for this investigation, quite rightly, do not extend to an examination of the role performed by Legal Practice 1 in this case. That said, it is difficult to totally disregard their involvement in it. This

report has already mentioned the tone and content of some of the correspondence that was sent by them to HMP Whitemoor. In addition, Solicitor 1 has helpfully expressed a retrospective personal opinion in relation to some of the issues raised during his interview with the lead investigator. Different people will undoubtedly have a different view on Legal Practice 1's style of engagement and the impact that it may have had on Mr North's ultimate removal from the Segregation Unit. Solicitor 1's position remained clear in that they represented Mr North's interests and followed his instructions following contact with him. A final comment to the lead investigator during interview was, *"It's never occurred to me that a prison law solicitor would have that degree of influence. All we were threatening to do was take them to court"*.

- 10.64 The role of Legal Practice 1 will be dealt with further on in this report when the decision to return Mr North to C wing on the 6th September 2008 is examined in greater detail.
- 10.65 What should be placed on record is the fact that Solicitor 1 was most co-operative with the lead investigator throughout. Following Mr North's authority to waive legal privilege, his case files were handed over to the lead investigator for examination, yielding additional information that had not been previously made available.
- 10.66 In October 2014 Solicitor 1 wrote to the lead investigator in relation to a number of issues. He specifically requested that the Draft Report make it very clear that the responsibility for any action taken by his practice,

including the contents of letters, was wholly his and that at all times Legal Practitioner 1 was acting under his direction and supervision. In addition, he was clear that he does not consider that he, or any employee of his practice, had acted either inappropriately or unprofessionally.

KEY FINDING 8.

Throughout his period of segregation Mr North continually challenged the decision, and indeed the necessity, to keep him segregated for his own protection. He continually stated to staff and managers at HMP Whitemoor that he was not at risk of further assaults from other prisoners at the establishment. He also sought the assistance of his (then) solicitors, Legal Practice 1, in order to try and secure a return to main location. This included Mr North sending them a handwritten note stating that he had not been assaulted in the gymnasium but had suffered an accident. In his second interview with the lead investigator Mr North agreed that these actions were less than helpful. Subsequently, via his current solicitor, Mr North states that he did so because his main concern was to get out of Segregation. Acknowledging that he had been assaulted would, in his opinion, have justified his ongoing segregation.

KEY FINDING 9.

Between the 3rd July 2008 and 6th September 2008 Mr North had a number of opportunities to provide staff at HMP Whitemoor with information that would have assisted them with the management of any ongoing risks to his welfare. He continually refused to do so and on some occasions actually lied about either what had happened or what he knew. He did not, and does not, accept that he had any obligation to assist staff who were charged with managing his safety.

KEY FINDING 10.

Every indication suggests that Mr North was rightly segregated on the 22nd July 2008 under Rule 45 for reasons of his own protection. PSO 1700 which outlines the policy and procedure in relation to segregation was correctly applied throughout the whole period from initial sign-on through until his transfer to C wing on the 6th September 2008.

KEY FINDING 11.

Due to the unavailability of documents from HMP Whitemoor, it cannot be judged if all reasonable steps were taken by Population Management to relocate Mr North to another High Security Prison during his period of

segregation in August and September 2008. The investigation would have expected to find additional documents to support any further enquiries with other prisons had they taken place.

RECOMMENDATION 2. If they have not already done so, NOMS and HMP Whitemoor should consider if current procedures and staff training provide for the full and accurate completion of official prison documents. Adequate audit and storage arrangements should also be considered as part of any subsequent review. The investigation highlighted a high number of either incomplete, or missing, official prison records. HMP Whitemoor should consider the policy on retaining both draft and final copies of letters and ensure that a process is in place to readily differentiate between draft and final versions of documents.

CHAPTER 11.

DECISION TO RETURN MR NORTH TO C WING FROM SEGREGATION

11.1 As previously mentioned, HMCIP carried out a full announced inspection of HMP Whitemoor in January 2006 followed by an unannounced full follow-up inspection in 2008. With regard to the use of segregation, the

Chief Inspector commented that the Segregation Unit was being inappropriately used as a long-term place of safety and some men stayed there for long periods of time without a clear individual progression plan.

11.2 Chapter 10 of this report has described the exchange of correspondence between HMP Whitemoor and Legal Practice 1 throughout the period when Mr North was located within the Segregation Unit. It also referred to an aborted attempt on or around the 27th August to move him out of the Segregation Unit and back to A wing.

11.3 As part of this investigation, the lead investigator conducted interviews with a number of staff who were Governor Grade managers at HMP Whitemoor during the relevant periods of 2008. It was established that each weekday morning, at or around the start of the day, there would be an informal meeting of managers from across the prison who were working on that particular day. It would ordinarily be chaired by the Governing Governor or Deputy Governor, and if neither was available then the most senior member of staff who was on duty. The purpose of the meeting was to discuss the significant events of the previous 24 hours, any issues impacting on that particular day and, if it was a Friday, any specific issues that were planned or likely to arise over the course of that weekend. It was normal practice for the Duty Governors for the forthcoming weekend to be in attendance at the Friday meeting. The meeting was described as normally lasting anything between 10 and 30 minutes. It was not minuted.

- 11.4 The investigation focused on the meeting that was held on the morning of Friday, the 5th September 2008. Given the absence of any written record and the fact that the witness interviews were taking place over two years after the event, it is unsurprising that recollection of events was in some cases very vague, and in others, contradictory to that provided by colleagues.
- 11.5 It would appear clear that the meeting of Friday 5th September 2008 was chaired by the Governing Governor, Governor 1. By way of background and context, he told the lead investigator that at that time he was attempting to change the culture at Whitemoor, specifically that of keeping people in segregation unnecessarily, for long periods of time. He said that the previous HMIP Inspection Reports informed his thinking in relation to this matter. He did recall a conversation taking place at the aforementioned meeting.
- 11.6 Governor 1 stated that what he had asked for at the meeting was a properly thought-through decision and that he would have told the managers present that, based on their knowledge and experience, he would expect them to come to a decision. He was quite clear in his instruction that if there was focused and specific intelligence then Mr North should remain in segregation. If not, he needed to be moved on. Governor 1 recalled that he stated that he wanted an informed decision by Monday morning and that any decision, as always, should reflect what was best for the prisoner. His recollection was that Mr North was used

as an example to highlight wider segregation issues and he did recall lecturing the Senior Management Team about the matter. Contrary to what some people had suggested, there was no way that he gave a direct instruction to anyone at that meeting to remove Mr North from segregation and return him to main location. He was absolutely clear on that point and further stated that he would not do that in a place like Whitemoor.

11.7 When asked by the lead investigator about the influence or otherwise of the correspondence from Legal Practice 1, and the associated threat of Judicial Review, Governor 1 was quite dismissive of the suggestion that may have had any impact on his decision-making in relation to this matter. He was very clear that he would never have allowed a solicitor to lead him into a decision that had not been properly thought through. In essence, the correspondence had no influence on his approach whatsoever.

11.8 The Duty Governors for the weekend of Saturday 6th September 2008 and Sunday 7th September 2008 were Governor 2 and Governor 5. Governor 2 recalled quite vividly being at the meeting on the morning of Friday the 5th September. Governor 5's recollection was less clear but she nonetheless did believe that she was likely to have been present. She certainly had no recollection of Governor 1 giving a direct instruction that Mr North was to be returned to main location.

11.9 In his account of events Governor 2 stated that in his opinion there was a very clear brief at the Friday morning meeting that Mr North should return to the wing over the course of the coming weekend. His interpretation was that the decision about Mr North's return had already been made and that it was his job, as one of the Duty Governors at the weekend, to make it happen. He was very clear that this instruction came from Governor 1, and considered it very unusual for the Governing Governor to communicate an operational decision, in such a direct way, at the morning meeting.

- 11.10 Governor 5 was of the view that it would have been surprising if the Governing Governor was not involved to some degree around the ongoing segregation of Mr North. She described that at that time the case was quite high profile within Whitemoor. In addition she stated that in her opinion, it would not have been unusual or out of character for Governor 1 to give out operational instructions to managers in this forum.
- 11.11 Governor 4, Head of Dynamic Security, had no recollection of Governor 1 giving out a direct instruction in respect of Mr North at the morning meeting. He believed that the Segregation Unit was most likely spoken about in general terms and Mr North cited as an example. He was clear in stating that it would have been wholly inappropriate for Governor 1 to have given out such an instruction and indeed would have challenged him if it had happened as other people have suggested. Governor 4 agreed that Governor 1 did have a view that the Segregation Unit was being used inappropriately and it needed to be emptied of people who didn't need to be located there. However, in his opinion, all Governor 1 did was request that he carry out a review of Mr North's circumstances to see if ongoing segregation was still necessary. Governor 1 didn't tell him the answer to the question, and had in fact never told him that any prisoner had to move. The lead investigator attempted to identify how many other prisoners were moved out of the Segregation Unit and back to the main wings during that weekend. HMP Whitemoor were unable to identify any records that would enable them to provide that information.

- 11.12 The accounts of events around the Friday meeting provided by both Governor 8 and Governor 6 tend to corroborate the account provided by Governor 2. Governor 8 informed the lead investigator that although his recollection was vague, he did seem to recall what he saw as an instruction from Governor 1 that Mr North was to return to the wing over the course of the coming weekend. His recollection was that it appeared that Governor 1 had made the decision already and he was just giving out instructions to make it happen. Unlike some colleagues, Governor 8 did not consider it unusual for this type of issue to be discussed at this meeting.
- 11.13 Governor 6 told the lead investigator that he remembered the meeting held on the morning of Friday 5th September 2008 very clearly. His interpretation was that Governor 1 gave a clear briefing to the weekend team that Mr North was to return to main location. He described the delivery of the message by Governor 1 as strong and that it had got to happen. He further stated that he found it quite surprising that the Governing Governor got so involved in such a matter and then was so direct with his instructions. He described it as a “*unique event*” and totally out of sync with how things normally happened. Given that he was the Governor who authorised Mr North’s initial segregation, Governor 6 stated that he was surprised that a decision was being taken to put him back on the wing. That said, he did acknowledge that he was not privy to the current intelligence.

11.14 Two other Governors who were believed to be present at the meeting in question, Governor 9 and Governor 10, had no recollection of events when interviewed. Governor 9, however, did consider that the issue around Mr North was fairly typical of the sort of thing that might have been discussed.

11.15 Governor 4 recalled the fact that the decision to return Mr North to the wings was made prior to the movement actually taking place on the morning of Saturday 6th September 2008. From memory he believed that the decision was taken the day before, Friday 5th September. He recounted how he believed that he had sat down with his Deputy, Governor 7, at some point during that day and carried out a proper risk assessment around Mr North and the likely impact should he return to main location. As part of this process, he stated he would have taken into account all of the intelligence held by the prison, representations from Legal Practice 1, Mr North's personal desire to return to the wings, and the likely effects on Mr North's welfare should he remain segregated. He also stated that he had further conversations with and took advice from Governor 1 prior to reaching an informed decision.

11.16 Whilst Governor 1 was unable to recall further dialogue with Governor 4 given the passage of time, Governor 4's account was most likely corroborated by Governor 5. She stated that as she was also Duty Governor on Friday the 5th September 2008 at some point in the afternoon she went to visit the Population Management staff, who had an office in the Security department, to try to get an update in relation to what was happening with Mr North. She was clear that the main purpose of her visit was to establish specifically if they were having any success in arranging a transfer away from Whitemoor for Mr North.

11.17 Governor 5 recalled seeing Governor 4 and Governor 1 talking at that time. She stated that they were either in Governor 4's office or the main Security office. Albeit that she walked in on the tail end of the conversation, she stated that they were clearly discussing Mr North and Governor 1 was asking Governor 4 appropriately challenging questions. In her opinion it was clear that Governor 4 had done a significant amount of research. She was told that Governor 4 had just completed a risk assessment and that, having examined everything that they had, his view was that Mr North should be returned to the wing. A conversation developed during which it was ratified as being agreed and Governor 1 confirmed that he was happy with the decision. She also stated that during this conversation a member of staff from Population Management came into the office and confirmed that at that time no other High Security establishment was willing to take Mr North on transfer. She was of the opinion that they were running out of options at that time and so with the threat of Judicial Review on the horizon, they reluctantly took

the decision to put him back on the wing. She considered that it was not something that they necessarily wanted to do, and that without the legal correspondence would probably not have done so at that particular time.

11.18 It was agreed that during the course of the weekend Governor 5 would make the transfer happen. Governor 4 stated that he wanted Mr North to go back to a different wing, which is a normal course of action for the prison to take if the source and nature of the threat was unknown and could not be identified. Governor 5 confirmed that because it was not known who had assaulted Mr North on the 22nd July it was not really possible to manage the risk.

11.19 As part of this investigation, the lead investigator was provided with a copy of a handwritten risk assessment that had been produced by Governor 4. According to Governor 4, the original note was contained within an A4, hardback, blue lined note book, hereinafter referred to as Governor 4's note book. This was used by him as part of his day to day duties. It was a normal, lined note book and not an official Prison Service document. The risk assessment, contained within the aforementioned note book, consisted of two and a half pages and was timed as having commenced at 14.30 hours on the 5th September 2008 and concluding at 15.30 hours on the same day. It was signed by Governor 4 and during interview with investigators he confirmed that it was his handwriting and he was the author. This document is referred to in greater detail later in this report at Chapter 17.

11.20 Using the aforementioned document as an aide-memoire, Governor 4 spoke during interview about the process that he had gone through when developing his risk assessment. He stated that he tasked the Security department at the prison with providing him all of the material that was held in relation to recent events involving Mr North. He stated that since Mr North had been in Segregation, the intelligence around him had effectively dried up and so the reality was that it was difficult to actually assess the risk that Mr North may or may not have faced. Upon closer examination, it was clear that there was no intelligence which identified any specific or imminent risk to his safety. He considered that the risk to Mr North at that time was likely to be no greater than that faced by any other prisoner at Whitemoor who was involved in criminality inside the prison. It is somewhat surprising that Governor 4 appears to have failed to fully consider the significance of the assault in the gymnasium on the 22nd July 2008 when carrying out his risk assessment, especially given that this had been the trigger for Mr North's segregation.

11.21 Governor 4 also spoke about the other considerations that formed part of his assessment. These included Mr North's ongoing desire to return to main location, the fact that no other High Security establishment was willing to take him, the legal correspondence from Legal Practice 1 and the associated threat of Judicial Review. With regard to Judicial Review, Governor 4 was clear that the legal challenge did form part of his thinking, however not to the point where it in any way changed the decision that he would have reached in any event. He was clear that if the intelligence case had justified it, he would have kept Mr North

segregated and gone to Judicial Review. His personal opinion was that the intelligence case did not support ongoing segregation and the Prison Service would have lost at Judicial Review. Finally, Governor 4 was at pains to emphasise that his main consideration when conducting the review was the mental and emotional wellbeing of Mr North. He considered that ultimately there was little to justify putting this at risk when balanced against the potential risk of further attack on Mr North.

- 11.22 Governor 4 was specifically asked about what had changed between the 3rd September 2008 and the 5th September 2008. On the 3rd he had spoken with Mr North and informed him that he was not going back on the wings, yet on the 5th, only two days later, the decision had been reversed. Governor 4 stated that he believed that Mr North probably knew far more about his recent assailants and the likelihood of further indiscipline than he was letting on. The conversation on the 3rd was an attempt to encourage him to pass on any information in his possession in order to assist with the ongoing assessment of risk.

11.23 The lead investigator was surprised to find that Governor 4 had had to rely upon the use of a plain note book to record his findings and thought processes when carrying out a risk assessment relating to the important issue of releasing a prisoner from the Segregation Unit back to main location. He was equally surprised that there did not appear to be any policy, procedural guidance or risk assessment matrix to assist with this process. The Segregation Policy (PSO 1700) in place at that time contained clear guidance and documentation in relation to the procedure to be followed when authorising an individual's removal to segregation and their management through the Segregation Review Board process. When the decision was taken at a Review Board, release of a prisoner from segregation appears to have been formalised and contained within the PSO. The anomaly appeared when the decision to release the prisoner from segregation was taken other than at a formal Review Board. This was put to a number of Governors who were interviewed as part of the investigation and without exception all agreed that this was a matter that needed to be addressed. If it has not already done so, the Prison Service may want to consider reviewing the policy, guidance and risk assessment matrix associated with this process.

11.24 Mr North seemed to recall that he was informed of his impending return to C wing from segregation during the afternoon or evening of the 5th September 2008. He stated that he was unhappy about the prospect of going to C wing given that he had effectively had to remove himself from that wing, and into segregation, upon his arrival at Whitemoor on the 3rd July 2008 because he had felt at risk from certain other prisoners on that wing. He claimed that as a consequence, he immediately raised these concerns with the Officer who had spoken with him about this matter but was effectively told that he would again be put on report if he made a fuss or refused to comply. Mr North did provide a physical description and surname, as he believed it to be, of the Officer concerned however enquiries failed to identify who that person was. The lead investigator is in possession of a letter to him from the Head of Discreet Units at HMP Whitemoor stating that all reasonable enquiries to identify the Officer have been carried out by the prison but without success. In addition none of the prison records assist with this task.

11.25 Governor 4 confirmed that after the decision had been taken on Friday, at some point Segregation and Residential would have been updated. In addition the wing would have been informed that Mr North was coming to them. The Duty Governor and Oscar for Saturday would also have been briefed and given an instruction to make it happen. He confirmed that the Intelligence Unit would have had a significant input in deciding which wing Mr North would be going to.

11.26 Officer 4 was at this time an Officer within the Segregation Unit. He was spoken to by the lead investigator on a number of issues associated with this investigation. One aspect that he spoke about was receiving what he described as two conflicting telephone calls from Governor 4. His opinion was that both of these calls were on the morning of Saturday 6th September 2008. Records have established that Officer 4 was on duty, on day shift, in the Segregation Unit on both Friday the 5th and Saturday the 6th September. He recounted how he recalls being in the Segregation Unit office when taking both of the aforementioned calls. During the first call he states that Governor 4 told him that he was going to decide who could leave the Unit, but in any event Mr North wouldn't be going back to the wing. In the second phone call from Governor 4, Officer 4 said he was told by Governor 4 that Mr North was now going back. Officer 4 informed the lead investigator that he specifically remembered these two phone calls because, although within a relatively short period of time, the second totally contradicted the first. He did say that as far as he could recall there had been some talk about Mr North going back for some time. Officer 4 concluded by stating that he

believed that it was only about an hour or two after the second call that Mr North left the Segregation Unit for C wing.

11.27 Officer 4's account of events was put to Governor 4, given that it appeared to be at odds with the accounts given by others. Governor 4 could not recall the conversations with Officer 4 in relation to this matter. That said, given the passage of time between the event and the interview that is not unsurprising. Governor 4 believed that any such conversation was most likely to have taken place on the afternoon of Friday the 5th September as opposed to Saturday the 6th September. He reinforced this view by stating that in normal circumstances he would indeed have informed the Segregation Unit himself of his decision and he was not at work on Saturday the 6th September.

11.28 Enquiries have indeed established that Governor 4 was not in work on either Saturday the 6th or Sunday the 7th September 2008. He was next in on Monday the 8th September. All of this is confirmed by both the Prison Gatekeepers Log, the purpose of which is to record all movements in an out of the establishment, and the Governors Duty Rota. Governor 4 immediately dismissed any likelihood that he could have phoned into the prison during off duty time. Whilst not in any way seeking to discredit Officer 4, when taking everything else into account, it would appear possible that Officer 4's recollection of events is somewhat confused. It may even be the case that he was mixing up the events of the previous week when decisions around Mr North and his ongoing segregation were subject to change.

11.29 Whilst there are differing accounts around how and why the events of Friday the 5th and Saturday the 6th September unfolded, that is in some ways to be expected given the passage of time and the number of people involved in this scenario. There appear to be two distinct, and different, interpretations around what was said at the morning management team meeting on Friday the 5th. Governor 1, Governor 4 and Governor 5 were of the opinion that there was a general discussion around individuals being located in the Segregation Unit where Mr North's case was used simply as an example to illustrate the points being made. The understanding of that trio is along the lines that Governor 1 did give a general instruction for managers to review the situation.

11.30 Messrs Governor 2, Governor 6 and Governor 8 were much more of the opinion that Governor 1 had already made the decision that Mr North was returning to the wing and was effectively passing on an instruction to the weekend staff to make it happen.

- 11.31 If looking to corroborate one or other account, then it is perhaps helpful to look at the events of that Friday afternoon and the evidence of Governor 5, in particular her conversation with Governor 1 and Governor 4 during her visit to Population Management. It would appear that she walked in on the risk assessment / decision-making process whilst it was taking place. It would be reasonable to conclude therefore that the meeting would not have taken place at that time of the afternoon if the decision had already been made by the time of the morning meeting. In any event, what would appear to be clear is that the decision to return him to the wing was discussed or endorsed during the afternoon. Whichever version of events is correct, the lead investigator is content that all staff passed on their genuinely-held account in good faith believing it to be an accurate record of their understanding.
- 11.32 Whilst taking into account the frailties of the process for taking someone out of the Segregation Unit out of committee, based upon the evidence available, Governor 4 does appear to have carried out an ordered and robust risk assessment. He states that he took into account the key issues of intelligence, legal representation, Mr North's wishes and primarily Mr North's welfare when reaching his decision. Both options carried an element of risk, and based upon the intelligence held by the prison, Governor 4 should not be criticised for making the decision that he did. He did not have the benefit of hindsight or the information known to Mr North about his previous assailants, which was information that Mr North chose not to share with the prison. That said, the ongoing option available to Governor 4 was the transfer of Mr North to another High

Security Prison. There is no evidence to indicate that he considered this during his risk assessment on 5th September 2008. During interview some staff at HMP Whitemoor expressed a personal opinion that they were surprised when Mr North was relocated into the main part of the prison from Segregation on 6th September 2008. Whilst not questioning their opinion or the basis for it, they were not in possession of the information held by Governor 4, or charged with being accountable for the consequences that might result from that decision. The question could be posed 'what has changed from a threat and risk perspective between 22nd July 2008 and 6th September 2008?' The reality would appear to be, very little, based upon the information and intelligence available. It has been stated that the incoming information relating to Mr North had all but dried up by 5th September 2008. It is clear that locating a prisoner in Segregation carries both risks and benefits. One of the benefits is to allow prison managers to buy time to allow for any new intelligence to enter the system in order for the risk assessment to be better informed. That would appear, in part, to be what has happened on this occasion.

11.33 It is unclear who informed Mr North of his move to C wing or indeed if Mr North did protest as he stated when informed of that move. It is unlikely that that will ever be established with any degree of certainty. However, what is now clearer after this investigation is that had Mr North chosen to share the possible identity of at least one of his alleged attackers and the details that were known to him, then he would most likely never have been located on C wing and almost certainly not on Green Spur. Unbeknown to the prison, including Governor 4, the prisoner (Prisoner 1) located only two cells away from where Mr North was eventually to be located on C wing on 6th September was one of the prisoners alleged to have assaulted Mr North in the gymnasium on 22nd July. Elsewhere this report outlines how that same individual is suspected of being involved in the subsequent, and more serious, attack on Mr North on the afternoon of Saturday the 6th September 2008.

KEY FINDING 12. Prior to Mr North being returned to C wing from the Segregation Unit on the 6th September 2008, there was very little intelligence held by HMP Whitemoor to suggest that he was at risk. Most of the intelligence held related to the previous assault on the 22nd July 2008 in the gymnasium. The intelligence that did exist, was prisoner-generated, with the inherent risks regarding motivation and manipulation. Furthermore, it was non-specific and uncorroborated. The intelligence did not provide any indication as to

why, from whom, or from where there was any threat to Mr North. The only indicator referred to his ongoing dispute with Muslim prisoners. Mr North did not appear, based upon what was known and recorded, to be at significantly greater risk than that faced by numerous other prisoners at Whitemoor. It is somewhat surprising that Governor 4 appears to have failed to fully consider the significance of the gym incident on the 22nd July 2008 when carrying out his risk assessment, especially given that this had been the trigger for Mr North's segregation. That said, the intelligence and evidence available to the lead investigator indicates that, on the balance of probabilities, it was the right decision to return Mr North to C wing on the 6th September 2008. Governor 4 did not have the benefit of hindsight.

KEY FINDING 13.

Had Mr North chosen to cooperate with prison staff and assist with the identification of his suspected assailants from the 22nd July 2008, he would almost certainly not have been moved to C wing, Green Spur, on Saturday 6th September 2008. One of them, Prisoner 1, was now located in a cell two doors along on the same landing from where Mr North was located on Saturday the 6th September 2008. Prisoner 1 was one of two individuals subsequently segregated on suspicion of being involved in the second attack on Mr North on Saturday 6th September 2008.

RECOMMENDATION 2.

If they have not already done so, NOMS and HMP Whitemoor should consider if current procedures and staff training provide for the full and accurate completion of official prison documents. Adequate audit and storage arrangements should also be considered as part of any subsequent review. The investigation highlighted a high number of either incomplete, or missing, official prison records. HMP Whitemoor should consider the policy on retaining both draft and final copies of letters and ensure that a process is in place to readily

differentiate between draft and final versions of documents.

RECOMMENDATION 5. If it has not already done so, NOMS should consider reviewing PSO 1700 relating to segregation. Any such review should consider including policy, procedural guidance and a risk assessment matrix for the occasions when prisoners return to main wings from Segregation outside of the main Segregation Review Board process.

RECOMMENDATION 7. NOMS may wish to consider whether the introduction and use of bespoke bound notebooks would be appropriate for use by personnel engaged in the management of serious or critical incidents. Similar documents are in use in other organisations for the purpose of recording, in one place, notes, thought processes and subsequent decisions.

CHAPTER 12.

TRANSFER OF MR NORTH FROM SEGREGATION TO C WING

6TH SEPTEMBER 2008

12.1 Records show that Mr North left the Segregation Unit for his transfer to C wing at 10.45 hours on the morning of Saturday the 6th September 2008. He arrived on C wing at 10.50 hours that morning. The Segregation Unit Daily Diary of Movements records the fact that Mr North left the Segregation Unit for his transfer to C wing escorted by an officer and in the company of two prisoners. It was not immediately obvious from the record who the escorting Officer was on this occasion. Enquiries by the lead investigator established that this was Officer 4. Officer 4 was a member of staff working on the Segregation Unit. The other two prisoners were located on C wing but sent to the Segregation Unit on a daily basis to clean. However, by the time of this investigation that arrangement was no longer in place and the Unit now uses its own prisoners as cleaners.

12.2 During interview Officer 4 stated that historically, he had had a number of conversations with Mr North whilst he was located in Segregation. In his opinion, Mr North wanted more than anything to return to the wings as he did not consider himself to be at risk or under threat. During the five-minute walk from the Segregation Unit to C wing he wanted to have another conversation with Mr North in order to gauge how he was feeling, however this was not possible due to the presence of the two cleaners. It transpires that Mr North did not talk at all during that time.

Officer 4 was clear that at no time did Mr North indicate any concerns or fears about moving to C wing, in fact he described him as appearing “*quite eager*”.

12.3 Mr North confirmed to investigators that as far as he can remember he did not make any form of complaint or protest about his transfer to staff on the morning of Saturday 6th September 2008, including to the escorting Officer, Officer 4. He did recall the walk from Segregation to C wing, including the fact that the two cleaners were present. He confirmed that whilst he had some concerns about moving to C wing, the reality was that he was just pleased to be moving out of Segregation and back on to normal location.

12.4 On the morning of Saturday the 6th September 2008 the manager in charge of C wing was Senior Officer 4. It was noted by the lead investigator that Senior Officer 4, a highly experienced Officer, presented himself as a professional and capable member of staff who took significant pride in his work and displayed great respect for both his staff and prisoners under his care.

- 12.5 Senior Officer 4 described to the lead investigator how during the working week prior to the 6th September there had been some discussions between Security and the wing around the likely transfer of Mr North out of Segregation and onto C wing. He stated that he was aware of the fact that Mr North was allegedly under threat and for that reason did not really want him on his wing. He could not recall at interview if he had actually expressed his personal concerns to anyone else, official or otherwise, in the establishment. He believed that at that same time some other staff on C wing may have been aware of the proposal to move Mr North to them, a fact later corroborated during further interviews with some of his colleagues.
- 12.6 Helpfully, Senior Officer 4 also explained that if a prisoner at HMP Whitemoor (but not just there) was under threat, then to a degree it mattered not which wing he was on. Again, other colleagues supported this view, as prisoners from all wings regularly came together for activities such as workshops, gym, prayers and visits. He stated quite clearly that the only way that he could have guaranteed any prisoner's personal safety whilst on the wing would have been to leave him locked behind his door. He described this as not only being worse for the prisoner than Segregation, but in any event also totally impractical.
- 12.7 Senior Officer 4 recalled being informed on that Saturday morning that Mr North was coming to his wing. Given the fact that at that time there were vacant cells on Green Spur he tasked the Officer in charge of the spur, Officer 5, to prepare a cell for Mr North. He was subsequently

allocated a ground floor cell, C1-033. Senior Officer 4 vaguely remembered Mr North arriving at the Centre Office on the wing but had no recollection of who either the escorting Officer or the two cleaners were. He was of the belief that he would then have passed Mr North over to Officer 5 for him to show Mr North to his cell. He had no first hand recollection of this, neither did Officer 5. However this process would have been normal routine for new arrivals. Officer 5 only recalled having any contact with Mr North later that day following the assault on him. Given the passage of time, it is not unreasonable to expect that there will be gaps in people's memories, especially when recounting more mundane tasks that they undertake numerous times on a daily basis.

12.8 Helpfully, Officer 4 recalled events in a little more detail. He remembered that he was the person who unlocked and relocked the gate by the Centre Office to allow Mr North to walk through onto Green Spur to be met by a member of the wing staff. He could not recall who that was but logic suggests that it would have almost certainly been Officer 5. What Officer 4 also recalled, with some degree of clarity, was standing and watching Mr North for a short period as he made his way onto the spur. He stated that, given the prison was in a state of unlock for Association, he was interested to observe any actions or shouting both by Mr North and/or other prisoners. He stated that there was nothing.

12.9 The lead investigator specifically asked Senior Officer 4 if he had any recollection of Mr North protesting about his transfer to C wing upon

arrival. His response was quite clear on this point. He stated that there were no such concerns around safety raised by Mr North, and had there been then he would have referred the matter back to either the Orderly Officer or Duty Governor for a review. He was asked about staff manning levels on the wing on Saturday the 6th September 2008. He confirmed that the prison operated a strict minimum staffing level which was agreed between Managers and the Prison Officers' Association (POA). Upon examination of duty rotas for that day, it was acknowledged by Senior Officer 4 that the number of staff on duty was in accordance with that agreement. He was also clear that had that not been the case, the prison / wing would not have been unlocked. The lead investigator was satisfied that this was indeed the case. Following discussions with NOMS, the lead investigator has supported the request not to disclose or make public details of staff numbers as it is considered that such disclosure has the potential to compromise both security and good order and discipline at the prison. The lead investigator readily acknowledges this and is in full agreement.

- 12.10 The C Wing Diary Sheet for the 6th September 2008 has an entry showing "12.15 *One to A Wing*". Although not named, there would appear little doubt that this entry relates to Mr North. As per standard practice at Whitemoor at that time, when a prisoner was released from Segregation to a wing other than the one on which he was located previously, he was taken to his previous cell on his old wing, to pack his kit and move it to his new location. There is a later entry on the C Wing Diary Sheet showing "14.00 *One in from A Wing*". Mr North confirms

that he was taken to A wing over the course of the lunchtime period in order to collect his belongings.

- 12.11 During interview, Senior Officer 4 described this process. He confirmed that on Mr North's first arrival on Green Spur it would have been in a state of unlock. Mr North would have had his lunch on the wing at or around 11.20 hours prior to the wing lunchtime lockdown. Mr North would not have left C wing to go and collect his kit until the prison was in a state of lockdown and whilst on A wing packing his kit he would have been locked behind his door.
- 12.12 Mr North would have arrived back on C wing, together with his kit, around the time of afternoon unlock. The Prison Control Room Log shows "13.52 – 'A', 'B' & 'C' Wings unlocked". This is because, as per standard operating procedures, a minimum number of staff was required on each wing in order to facilitate the unlocking process. After unlock for afternoon Association, he would have been able to either remain in his cell or mix with all other prisoners across Green Spur as he saw fit.
- 12.13 The prison Control Room Log records the fact that the two Governor Grades on duty in the prison on the morning of Saturday the 6th September 2008 were Governor 2 and Governor 5, both of whom were Grade E. The two Principal Officers on duty were Principal Officer 4 and Principal Officer 1. Whilst Governor 2 and Governor 5 were aware of Mr North's move from Segregation to C wing that day, as would be normal for such routine tasks, they did not have any hands on involvement in

making it happen. Their respective roles become more relevant as events unfolded later that afternoon and will be covered later on in this report.

12.14 The Orderly Officer (Oscar 1), Principal Officer 4, was interviewed by the lead investigator. His role is described as being in charge of running the operational regime of the establishment and acting as scene commander as and if there was an incident anywhere in the prison. As was normal routine, he had an Oscar 3 on duty whose role it was to assist and if necessary deputise for Oscar 1. On this particular day Principal Officer 1 was Oscar 3. Both were equal grade Officers. Principal Officer 4 informed the lead investigator that he had no recollection of being told on the morning of Saturday the 6th September 2008 of Mr North's impending move. Whilst not certain, he did believe that had he been told then he would have remembered. He stated that this was because he knew Mr North and knew what he was like. He clarified this by stating that "*wherever he went trouble was bound to follow*". He described him as "*quite troublesome*", even when compared to other problematic prisoners in HMP Whitemoor.

12.15 Returning to the interview with Senior Officer 4, he informed the lead investigator that as a matter of routine he held a briefing with his staff who were on duty before every morning unlock and every afternoon unlock. Although he could not recall specifically the briefing for the afternoon of Saturday the 6th September 2008, he was absolutely clear that such a briefing would have taken place and it would have been at

approximately 13.40 hours. No records were kept of the briefings but he was clear that staff would have been informed that there was a new arrival, Mr North, and that he had come in to them from the Segregation Unit. Some of the other wing staff interviewed did have a vague recollection of Mr North being mentioned by Senior Officer 4 at this briefing.

12.16 Senior Officer 4 confirmed that prior to Mr North's arrival on the wing he did not receive any specific briefing or instructions in respect of Mr North. He was not made aware by Security of any specific threat or risk to his welfare. As far as he was concerned, Mr North's arrival on the wing in these circumstances, meant that he was to be treated like any other prisoner on normal regime. Indeed Senior Officer 4 was clear that he would not have had the resources to have treated him any differently. That was also the understanding of other staff on duty on the wing. In addition it is clear that Mr North himself certainly never expressed any concerns or requested any special assistance from staff. During interview Mr North stated that at that point he did not consider that there was any point raising the matter any further with staff on C wing. He was of the opinion that had he done so then there was every possibility that he would have found himself back in Segregation. It is unclear quite what his rationale or evidence base for that approach was.

12.17 The Head of Security, Governor 4, was asked about the process for taking account of representations from wing staff if they were of the opinion that a certain prisoner should not be located on their unit,

particularly if it was a matter around security, safety or welfare. He was very clear that such representations from wings were quite a common occurrence, especially if they knew the history of a prisoner and he had a reputation for creating problems or presenting specific challenges. Governor 4 was of the firmly-held view that it would not have mattered how many wings or cells there were at HMP Whitemoor, because of the type of prisoner that he was, nobody would have wanted Mr North. The key issue remains that the wing staff do not have access to intelligence or security information. That is the sole preserve of Security staff. It is their job to make a balanced and informed decision, based upon all of the evaluated intelligence, whilst at the same time taking into account all of the wider issues, and any impact such moves are likely to have across the whole establishment. Such moves are not and should not be made in isolation. It is their job to take gossip, emotion and personal preferences out of the decision-making process. The lead investigator both understands and fully endorses this approach.

- 12.18 In addition, both Governor 4, and his deputy, Governor 7, confirmed that in the case of Mr North there was no phased reintegration programme around his return to the wing from Segregation. In their opinions, any such move would require the buy-in from the recipient (Mr North) and at that time they did not consider that he was the type of prisoner who would associate himself with, or comply with, any such strategy. As has been mentioned previously, Mr North would not even acknowledge that he faced any form of risk from other prisoners. Staff were of the opinion that he was not the type of prisoner who would want help. It was

described as being a “*Kudos thing*”. In the opinion of the lead investigator, quite properly Mr North was not consulted in this instance about his choice of wing.

- 12.19 Governor 7 confirmed that there was an anti-bullying strategy in place in 2008 for both victims and perpetrators. This has now been replaced, however given the circumstances of this case the strategy was not suitable to manage any potential risk to Mr North, particularly given that the type of risk and its likely origins were totally unknown to the prison staff. This is acknowledged by the lead investigator.

- 12.20 The collator on duty on C wing on Saturday the 6th September 2008 was Officer 6. In interview, he described the role of collator as being almost a “*right hand man*” for the Senior Officer, answering the phones, updating records, generally making sure that everything got done as efficiently as possible. He stated that whilst he had no recollection of ever having previously met Mr North, he was aware of him and the circumstances surrounding his segregation. He could not recall how he knew. He was of the belief that Mr North’s problems resulted from him refusing to convert to Islam.
- 12.21 From memory, he thought that he had possibly been aware of Mr North’s likely transfer to C wing for a few days prior to it actually taking place. This tends to support the account of Senior Officer 4. Officer 6 confirmed that he did not actually know that the transfer was going ahead until the morning that it actually happened. He believed that either he or Senior Officer 4 would have taken the initial call notifying them of the impending transfer.
- 12.22 During interview, Officer 6 expressed a personal opinion that it was a mistake by managers to move Mr North from the Segregation Unit to C wing, given the perceived threat to his safety. He did qualify that by acknowledging that he was not privy to either intelligence or security material, which was the very point highlighted by Governor 4. He did also add that if the threat to Mr North was from Muslim prisoners that it would not really have made much difference where he was located within the prison. His safety would have been compromised on any of the

wings as there was a high Muslim population across the whole establishment. In this context it could be argued that it may have been safer to keep him in segregation until transferred to another prison. That said, it is clear that similar challenges to Mr North's safety existed across the High Security Estate.

12.23 As part of this investigation the lead investigator spoke or attempted to speak, to a number of prisoners who were located on C wing on or around the 6th September. There was a general view expressed by them that they did not know that Mr North was coming to the wing until he actually arrived on the morning of the 6th. However, it was suggested that prior to this his presence in the Segregation Unit was something of a topic of conversation amongst other prisoners, particularly Muslim prisoners.

12.24 One prisoner, himself Muslim, informed the lead investigator that the assaults on Mr North were actually nothing to do with his refusal to convert to the Muslim faith as appeared to be being suggested. He stated that Mr North, for a variety of reasons, had many enemies within several prisons and that Security knew that this was the case. He believed that it was simply a case of Mr North's past catching up with him.

RECOMMENDATION 5. If it has not already done so, NOMS should consider reviewing PSO 1700 relating to segregation. Any such review should consider

including policy, procedural guidance and a risk assessment matrix for the occasions when prisoners return to main wings from Segregation outside of the main Segregation Review Board process.

CHAPTER 13.

DISCOVERY OF MR NORTH POST ASSAULT – 6TH SEPTEMBER 2008

- 13.1 Mr North returned to C wing from A wing at around 14.00 hours on September the 6th. During interview, Officer 7 told the lead investigator that she specifically recalled Mr North returning to C wing at approximately 14.00 hours with his kit. This was very soon after unlocking for the afternoon Association period. She recalled that she and Officer 8 went to Mr North's cell with him, G1-033, to unlock the door for him. Officer 7 stated that from memory Mr North didn't speak at this time and certainly made no comments about not wanting to be on C wing. She had no recollection of there being any unusual atmosphere on Green Spur that afternoon or indeed the arrival of Mr North generating any type of unusual interest or activity. As far as she was concerned he was then left to his own devices, presumably with him having the intention of unpacking his belongings.
- 13.2 One of the Officers on duty on C wing that afternoon was Officer 9. He knew of Mr North, although not that well, from his previous periods in HMP Whitemoor. He also remembered having a brief "*welfare chat*" with him in July 2008 whilst Mr North was on A wing. He was of the belief that Mr North had both historical, and potentially ongoing, issues with Muslim prisoners, although during this conversation Mr North had told him that he was OK. Whilst Officer 9 was not sighted on the issues in any great detail, he informed the lead investigator that he actually mentioned this at the afternoon briefing session as he believed that it

was something that staff should be aware of, especially given that Mr North was coming from Segregation having been there for his own protection.

- 13.3 One of the Officers on duty on C wing that afternoon was Officer 10. His duties were those of cleaning Officer for the whole of the wing. Between approximately 14.20 and 14.30 hours Officer 10 went to Mr North's cell to arrange the provision of a television set for him. Mr North remembered asking the cleaning Officer for a television but has no recollection of any events thereafter. Officer 10 had never met Mr North, although he recalled hearing that he had been involved in previous altercations with Muslim prisoners. He describes how, upon walking into Mr North's cell, he found him sitting on his bed with clearly visible cuts to his head, wrists and arms. Mr North was alone in the cell but there was a significant amount of blood visible on the floor, bedsheets and cupboards. He also appeared to be disorientated. Mr North at this point told Officer 10 that he had fallen over, something that the Officer knew to be incorrect as Mr North looked as though he had received a "*good beating*".

- 13.4 Officer 10 immediately sought assistance from two other members of staff who were on duty on Green Spur and in the immediate vicinity. Officer 5 and Officer 8 at that time were patrolling the Green 2s landing, up one floor but almost opposite the cell occupied by Mr North. They both made their way to join Officer 10, and he then went to the Centre Office to notify the Senior Officer, Senior Officer 4, and the collator, Officer 6, about the incident.
- 13.5 Officer 5 told the lead investigator that he didn't know Mr North prior to becoming involved in this incident. Neither was he sighted on his history or any potential threat to his safety. In reality Mr North was simply another one of approximately 40 prisoners on the spur at that time. Officer 5 described the inside of Mr North cell as a "*bloodbath*". He stated that Mr North at that time was sitting on his bed with his head in his hands, covered in blood. Officer 5 immediately got an already blood-splattered sheet and used it to bandage what appeared to be a significant cut to his head. At this time Mr North purportedly said on a few occasions "*it's over*", then said that he had been attacked in the shower and then said he had been attacked in the gym. Officer 5 described him as being a bit delirious and a bit confused.

13.6 Officer 6, upon being informed of the incident immediately made his way from his collator's position within the Centre Office to Mr North's cell. He described Mr North as sitting on his bed in an unsteady position with significant quantities of blood covering his face and back of his head. His hands were also covered in blood with a significant laceration to his right wrist. Mr North was observed by Officer 6 to be unsteady on his feet when he stood up and had slurred speech. Mr North informed Officer 6 that he had been attacked by five Muslims. Officer 5 and Officer 6 then escorted Mr North from his cell and off Green Spur to the Centre 1s landing area in order to await the arrival of Healthcare staff. Subsequent to this incident, Officer 10 made an appropriate entry in the C Wing Observations Book.

13.7 The prison Control Room log for Saturday the 6th September 2008 records that at 14.30 hours Senior Officer 4 notified the Control Room that Mr North had been assaulted by up to five prisoners at approximately 14.25 hours and that he had lacerations to his head, arms and body. The log also records the fact that Healthcare staff were en route and that both Victor 1 and Oscar 1 had been informed.

13.8 The Report of Injury to Inmate Form (F213) completed by Officer 10 contains an entry by a member of Healthcare staff, Officer 16, who attended to Mr North in the Centre 1s at 14.30 hours that afternoon. The record states that Mr North appeared disorientated, and was unsteady on his feet. He was then transferred to Healthcare for further assessment. This is corroborated by the Control Room Log which records a message from Oscar 1 timed at 14.37 hours stating that Mr North was being moved to Healthcare in a wheelchair. This information is replicated in entries in both the Prison Movements Log and the Prisoners Personal Record System.

13.9 During interviews with the lead investigator, staff that were on duty on the wing at the time of the attack on Mr North attempted to describe what the environment and atmosphere would have been like during a typical Association period and get a sense of any restrictions on what prisoners could do. In essence there could be up to 42 prisoners unlocked on each spur during Association and provided that they were on normal regime they could move freely across the whole spur. There was a rule of no more than three prisoners in any one cell at any time, and this was enforced by Officers. The prisoners could use a small kitchen to cook food, use the small gymnasium, play snooker, pool or table tennis, make phone calls and play their music. Staff described it as being a loud and sometimes quite chaotic environment, especially as the noise from all three spurs echoed around the whole wing. However, it was not a time when they generally experienced too many problems with prisoners. Areas for group congregation during the Association periods were the

pool and snooker tables. On Green Spur these were located almost directly outside the door of the cell occupied by Mr North. It is unclear if this in any way contributed to the ability of the offenders to attack Mr North without being detected. The lead investigator visited the spur during an Association period and can fully endorse the description provided by prison staff.

13.10 Staff told the lead investigator that the atmosphere on the wing on the day of the attack did not appear to be any different to any other day either pre or post the attack on Mr North. The activity around Mr North and his cell when he was discovered didn't appear to lead to any unusual levels of interest or activity by other prisoners. It was described as if everyone just carried on doing whatever it was that they were doing.

13.11 It was established that whilst this incident, if it happened now, would be easily captured on closed circuit television, no such equipment was fitted on the wing in 2008.

13.12 It was a long-standing Prison Service Instruction that during prisoner Association periods the bolts on the cell doors should be “*shot*” by staff to prevent the door from being closed without the use of a cell key. One of the main reasons for this was to prevent hostage and barricade situations from arising. As in many walks of life, routine working practices slip from time to time and instructions need to be reissued. Coincidentally, only two days prior to the assault on Mr North the Governing Governor at HMP Whitemoor, Governor 1, had issued both a Staff Information Notice and a Prisoner Information Notice reinforcing the requirement to comply with this Instruction. The lead investigator found it interesting to hear one of the prisoners during interview, indeed one of the suspects for the attack on Mr North, describe this practice as a contributory factor in relation to this assault, his rationale being that if the bolt had not been shot Mr North could have locked himself in his cell if he had felt under threat. Whilst only being able to speculate, in the opinion of the lead investigator, it is just possible that this working practice actually prevented Mr North from suffering even more serious injury since his attackers were unable to secure the door.

13.13 At around the time that Mr North was attacked, most likely shortly afterwards, Officer 9 was on duty on the Red 3s landing in C wing. He described to the lead investigator how he had a good view across into Green Spur and saw a prisoner named Prisoner 2 making his way up the Green 1s staircase at such speed that it caught his immediate attention. He considered this as being somewhat peculiar as Prisoner 2 was almost running. He continued to watch him and saw him head straight to the shower room on the Green 3s landing. Prisoner 2 was dressed in a red prison tracksuit but didn't have any other kit with him. Almost immediately Officer 9 saw another prisoner, Prisoner 1, go to the same showers but he just stood in the doorway. Within a short space of time Officer 9 witnessed what looked like a bundle of clothing being handed to Prisoner 1 from inside the shower room. Prisoner 1 immediately walked along the landing to the gate adjoining Blue Spur where he passed the bundle, through the bars in the gate, to an unidentified person located on Blue Spur.

13.14 Officer 9 went on to state that almost immediately after witnessing this scenario he was called to the Centre Office in C wing where he was informed of the assault on Mr North. Officer 9, who presented himself as a very credible witness, stated that he immediately informed Senior Officer 4 about what he had just witnessed. He also informed the Duty Governor, Governor 2, when he arrived on the wing. Officer 9's recollection was that this all probably happened in less than five minutes after Mr North was found by Officer 10. As per Prison Service Instructions, Officer 9 recorded what he had seen in the C Wing

Observations Book and he submitted a Security Information Report. Officer 9 further stated that after passing the aforementioned information on to the SO and Governor 2 nothing much happened as far as he could recall. In particular he remembered that the afternoon gym session went ahead as planned as he personally was responsible for searching all of the prisoners who were going to the gym as they left the wing. He recalled that Prisoner 1 was wearing the same clothes as previously, whereas Prisoner 2 had changed out of the red tracksuit.

- 13.15 The C Wing Observations Book for Saturday the 6th September contains an entry (not timed) by Officer 7. It refers to the assault on Mr North and states that after it had taken place she was standing on the Green 2s landing (no time stated) when she looked into the kitchen and saw Prisoner 1 being very animated. He was pretending to swing punches. He eventually noticed her and completely stopped talking and put his head down. In her opinion he appeared to be describing a fight. When spoken to about this by the lead investigator, Officer 7 could not recall this incident at all. When shown a copy of the Observations Book she did confirm that the entry referred to was indeed her handwriting. She could assist no further and was unclear whether she knew of the attack on Mr North or not at that time or what she did with that information. The lead investigator has located a Security Information Report dated the 7th September 2008 containing that information. The Action Taken column is blank.

- 13.16 Officer 11 told the lead investigator that although it didn't mean anything to her at the time, she recalled seeing Prisoner 2 visit the wing laundry room. She cannot remember what time that was on the Saturday afternoon other than with hindsight, it was around the time of the assault on Mr North. She described how Prisoner 2 went in carrying a bundle of clothing and then came out without anything. It is unclear what, if anything, happened to that information at the time.
- 13.17 It should be noted at this point that at no time during this scenario was the prison general alarm bell sounded. This is most likely due to the fact that when Mr North was found injured in his cell there was no continuing disorder or ongoing risk to either prisoners or staff. Whilst this will be covered in greater detail later in this chapter, it is possible that this in some way contributed to a disjointed approach to managing the incident and resulted in opportunities to identify the offenders and secure and preserve evidence being lost. Not least of all, the activation of the general alarm bell would have immediately resulted in a complete lockdown of the entire wing. Virtually every member of prison staff interviewed, regardless of grade, expressed surprise that the wing, or as an absolute minimum the spur, was not subject of an immediate lockdown.
- 13.18 Following his arrival in the prison Healthcare Centre Mr North was the subject of further assessment and medical treatment. An entry in his Prison Patient Record made by Senior Officer 7, describes Mr North as having concussion with visible cuts and stabbing injuries to the head. It

shows that at 14.45 hours SuffDOC (Suffolk Doctors On Call) was contacted by phone. This entry is replicated in the prison Control Room Log. An entry in the Prisoner Patient Record states that due to Mr North's deteriorating condition a decision was then made to call an ambulance. The ambulance arrived at 15.50 hours and Mr North was removed to hospital. Once again, these entries are corroborated by corresponding text in the prison Control Room log. Mr North left the prison for Hospital 3 in an ambulance with an appropriate prison staff escort at 16.35 hours.

- 13.19 During the journey to hospital Mr North informed the paramedic attending to his injuries that he had not been assaulted but had in fact fallen from a bench. This information is recorded on the East of England Ambulance Service Patient Assessment Form dated the 6th September 2008.

13.20 Prior to his transfer to hospital, in addition to his immediate medical requirements, Mr North was seen by two members of staff from the prison Dedicated Search Team (DST), Officer 12 and Officer 13. They had been trained in the search for, recovery and preservation of evidence following incidents such as assaults. At this time, with the exception of a head injury that had already been bandaged, they photographed Mr North's injuries and seized his clothing for any subsequent forensic examination. At that time Officer 12 was of the opinion that the injuries to Mr North did not look that severe. In his words, he had seen "*far worse*". This was also the opinion of his colleague, Officer 13.

13.21 Whilst still in Healthcare, Mr North was also spoken to by Governor 5. At that time Governor 5 was Victor 2, one of the two Governors on duty in the prison. Resourcing, responsibilities and the chain of command will be subject of comment later in this chapter. Governor 5 informed the lead investigator that she saw Mr North approximately one hour after he had been found by staff. She described him as being his normal "*quick-talking*" self. Even at that point he was asking to go back to the wings. Mr North informed her that he had fallen down the stairs. Whilst at odds with the other descriptions of Mr North's condition provided by staff at HMP Whitemoor, this was her personal recollection.

- 13.22 Governor 5 stated that she was unaware of the assault on Mr North until she knew that an ambulance had arrived at the prison. It was clear to her that her colleague, Governor 2, in his capacity as Victor 1 and Duty Governor, had been briefed by Control Room at the outset but had not made her aware at any point. Once aware she immediately made her way to Healthcare.
- 13.23 She was quite clear in her thinking, that in order to secure and preserve evidence and to assist in identifying the offenders, the whole wing should have immediately moved to a state of lockdown. However, by that stage she considered that the situation was beyond saving as prisoners had already gone to the gym and had had ample opportunity to dispose of evidence and collude with one another. In her opinion, by that time, any retrospective move to a state of lockdown would potentially have led to disorder and indiscipline with some prisoners refusing to comply.
- 13.24 Governor 5 conceded that although Mr North had visible serious injuries when she spoke to him in Healthcare, the full extent and severity of his injuries did not become clear to her until after further diagnosis at Hospital 1 and then Hospital 2 on Sunday the 7th September. Not unreasonably, one of her considerations when conducting the initial risk assessment and associated activity was to assess whether his injuries were in fact self-inflicted with the intention of going to an outside hospital as part of some elaborate escape plan. This was not an unreasonable consideration given the fact that Mr North had, albeit some years

previously, attempted to escape from a prison escort vehicle and used violence in the process.

13.25 The prison Control Room log for Saturday the 6th September 2008 records that at 16.05 hours, before Mr North even left the prison to go to hospital, there was an attempt made to contact the prison Police Liaison Officer, PC 1, via telephone. As a general rule, at that time the Police Liaison Officer performed his duties from Monday to Friday, with no arrangement or requirement for him to be on call. A message to contact the prison was left on his answerphone. Given this arrangement, PC 1 did not receive this message over the weekend and there was no contact between him and the prison during this time.

13.26 The lead investigator has examined a copy of the Cambridgeshire Police Control Room log for Saturday the 6th September 2008. This records that at 16.37 hours a call was received from Senior Officer 8 at the prison notifying them that a Category A prisoner was being transferred to Hospital 3 following an assault. Such a notification was in accordance with normal operating procedures for these circumstances. The entry states that the prisoner had cuts and bruises. From the information recorded in both the prison log and the Police log, there is nothing to indicate that there was any intention during this call to report this incident as a crime with the expectation that the Police would conduct an investigation. All indications suggest that this call was made, and treated as, a security matter alone.

13.27 Three prison staff, Senior Officer 5, Officer 14 and Officer 11 travelled with Mr North in the ambulance to the hospital. Senior Officer 5 was the Senior Officer in charge of the escort. Mr North was described by all as being in a confused, agitated and irrational state. Officer 6 and Officer 4 travelled in a following car. During the journey, and subsequently whilst at hospital, Officer 11 attempted to get Mr North to tell her and colleagues exactly what had happened to him. She recalled that he named and accurately described Prisoner 2. He didn't really go into any detail around how the attack happened but may have again made some mention of there being five assailants. She also recalled him saying that whilst he was on the floor he was kicked and a metal rod was used. He also said that it was a misunderstanding and he could understand why people didn't get on with Prisoner 2. She subsequently made an entry in the C Wing Observation Book in relation to these comments. Senior Officer 5 and Officer 14 had no recollection of him discussing the attack at all.

- 13.28 Following his treatment at Hospital 3 Mr North was declared fit for discharge and return to the prison by medical staff. His diagnosis and treatment at this time are the subject of comment within Chapter 16 of this report.
- 13.29 An entry in the prison Control Room log for that evening records that at 17.35 hours Senior Officer 5 contacted the prison from hospital to inform them that once Mr North had had his wounds stitched the hospital intended discharging him back to the prison with the proviso that he was to be located overnight in Healthcare with medically-trained staff. At approximately 18.20 hours the prison notified Police that Mr North was fit for discharge and arrangements were being made for his return to prison. This is recorded in both the prison and Police Control Room logs.
- 13.30 Upon his discharge from hospital, Mr North travelled back to HMP Whitemoor in a Category A van, a standard method of transporting Cat A prisoners. Mr North walked from the hospital premises to the vehicle. There is no evidence available to suggest that the hospital gave, or indeed considered it necessary to give, any advice around appropriate transport arrangements for this journey. Three prison staff travelled in the back of the van with Mr North, Senior Officer 5, Officer 14 and Officer 11. Officer 6 and Officer 4 again travelled in a following car.
- 13.31 It has been established that Mr North was placed in the front of the two internal cells that were in the rear of the van, in effect the one nearest to the driver. The cell was described by staff as being about three feet

square with a chair for the prisoner to sit on. There was also a seat belt fitted which, according to the Incident Report completed by Officer 14 was applied for the journey. The walls were made of a very hard plastic material and the door area was described as having a metal surround. There was also a small viewing window that enabled both staff to see in and prisoners to see out. There was also an internal light that could be switched on and off by staff. The van was described to the lead investigator as being very robust as it was designed to both protect the passengers and stop prisoners from escaping.

- 13.32 It was established that Mr North was sitting in the van facing forwards, in the direction of travel, with the door to his left. Senior Officer 5 was sitting on what was described as the Senior Officer's seat, so that the door to the cell was located immediately behind him.

13.33 During the course of the journey, which was about 30 minutes in duration, Mr North began banging his head on the internal walls of the cell. The escorting Officers stated that this was not a continuous act throughout the journey. It was something that he probably did on approximately five or six separate occasions. Officer 11 stated that she could hear the banging but didn't actually see Mr North. She recalled that he didn't say anything whilst doing it and he would stop for a short time when told to do so. Her opinion was that Mr North wasn't actually trying to harm himself; she considered it more likely that he was not in control of what he was doing.

13.34 Senior Officer 5 provided a similar account of events to those outlined by Officer 11. He did however look into Mr North's cell via the small observations window and saw him banging his head on what he described as both the front and the left side against the cell door. He expressed a somewhat different view in that he considered that this was a deliberate act by Mr North, possibly with the intention of making his injuries worse. He considered that they were very powerful movements of his head and certainly, in his opinion, sufficient to cause injury. He was clear that these acts were most definitely not associated with the natural movement of the vehicle.

- 13.35 The prison Control Room log records that Mr North arrived back at HMP Whitemoor at 19.18 hours. He was taken straight to Healthcare. Upon arrival, it was noticed that there were visible blood marks on the internal side of the vehicle cell door. It was described as being a fair amount of blood and it had the appearance of perhaps having been smeared on the surface. There were also further blood marks on the other internal walls but the majority were on the door. Mr North had also vomited.
- 13.36 Whilst Senior Officer 5 had no recollection of reporting the incident in the van to either the duty Principal Officer or the Healthcare staff that received Mr North back to the prison, he agreed that as officer in charge of the escort it would have been his responsibility to do so. He was confident that this information would also have been recorded on the Prisoner Escort Record (PER). The Principal Officer on duty when Mr North arrived back at HMP Whitemoor from Hospital 3 was Principal Officer 4. He recalled in interview that Senior Officer 5 did indeed show him the blood on the internal panels of the cell and made him aware of how it had originated.
- 13.37 The lead investigator made attempts to obtain a copy of the PER. This document has never been located, despite a search by staff at HMP Whitemoor. An official letter from the prison to the lead investigator states that all reasonable efforts to locate the document have been completed with no realistic prospect of it now being found.

13.38 It has been established that at the time of this incident there was no official guidance to staff regarding action to be taken should a Category A prisoner, being transported in a Cat A van, present as being unwell during the course of the journey. Not unreasonably, the official view is that staff should be expected to make an appropriate judgement based upon all of the prevailing circumstances. In the opinion of the lead investigator this does not appear to be an unreasonable approach as it would be an impossible task to develop standard procedures for all of the circumstances that may arise. Whilst the health and wellbeing of the prisoner is of prime importance, a key consideration is also the security of the prisoner and a safe return to prison at the earliest opportunity. Given the fact that Mr North had just been discharged from hospital having been seen by qualified medical staff and was undertaking only a relatively short journey, there would not appear to be anything to suggest that the escorting staff should have done anything other than what they did.

13.39 There is an entry in the prison Control Room log, originating from Oscar 1, which informed them that Mr North was in the Healthcare Treatment Room and referred to him banging his head during the journey. It stated that it was unclear if his actions were accidental or deliberate. At 19.40 hours Governor 2 was informed of these developments. He instructed that if Mr North had to go out to hospital again, then for security reasons it must be to a different hospital.

- 13.40 As the evening progressed staff in Healthcare became increasingly concerned about what appeared to be deterioration in Mr North's condition. At 20.15 hours Principal Officer 5 contacted the Control Room requesting that the duty Doctor be called. The Doctor subsequently spoke on the telephone to Healthcare at 21.40 hours. It would appear that by 00.38 hours the following morning, Sunday the 7th July 2008, Mr North's condition was continuing to cause concern. There was a further request for the Control Room to contact the on call doctor. Mr North was kept under observation as instructed by the Doctor and there were further telephone conversations between him and Healthcare over the course of the next couple of hours. By 03.47 hours there was concern that Mr North's pulse rate was unacceptably low and as a consequence at 03.58 hours Oscar 1 requested an ambulance via 999.
- 13.41 Both the Control Room log and the Gatekeeper's log record the ambulance arriving at the prison at 04.15 hours and departing with Mr North on board, bound for Hospital 1, at 05.25 hours.

13.42 During the period between the arrival of the ambulance and its subsequent departure from the prison, a number of key personnel were contacted by telephone in order to keep them apprised of developments. These included the on call Governor Governor 2, Governor 4 and the Duty Inspector in Cambridgeshire Police Control Room. It would appear that the purpose behind the contact with the Police was in relation to the security of Mr North given his Category A status, and not around the requirement to report what was increasingly looking like a very serious assault that had taken place within the establishment. As if to support that understanding, an examination of the Cambridgeshire Police Control Room log shows an entry timed at 04.19 hours showing a call from Senior Officer 9 at HMP Whitemoor where the Police Operator has categorised the '*Incident Type*' as "*Escort*". It goes on to state that there is a prisoner with a head injury and the prison are asking for a Police escort, which on this occasion the Police duly provided.

13.43 On arrival at Hospital 1 it was established that there was no capacity to admit Mr North. Other establishments were considered but eventually the decision was taken that he would need to be transferred to Hospital 2. However, prior to his transfer, a doctor at Hospital 1 stated to prison staff that if Mr North was an "*ordinary patient*" he would be sent home. Not unreasonably, this comment caused the Duty Governor, Governor 2, some concerns that Mr North might indeed be plotting an elaborate escape, especially given that in the ambulance during the journey he was struggling and demanding that the handcuffs be removed. That is

now known not to have been the case. This information is recorded on the prison Control Room log timed at 07.31 hours.

13.44 A second call was made at 04.29 hours to the mobile phone of the off duty Police Liaison Officer, again without success. Consequently, a further voicemail was left requesting that he make contact with the prison. It would appear that this was being considered as the only available mechanism for reporting the assault to the Police with the intention of it being investigated.

13.45 As part of this investigation, the lead investigator paid particular attention to how the scene of the attack, most likely Mr North's cell, was managed after he was found with what, even at the outset, presented as quite serious injuries. The key issues under consideration were what attempts were made to identify, secure and preserve evidence, in particular forensic evidence, and what was done to identify those responsible for the attack. The lead investigator also looked at the previously referred to ACPO/HMPS Memorandum of Understanding in so much as it refers to the reporting of crimes in prison to the Police. This has already been discussed in some detail in Chapter 9 of the report which examined the previous assault on Mr North in the gymnasium on the 22nd July 2008. The same issues arise again here.

13.46 At this point it is helpful to understand the management structure and Chain of Command for Saturday the 6th September 2008. As was normal at weekend there were two Governor Grade staff on duty,

Governor 2 and Governor 5, both of whom were Grade E. In addition there were two Principal Officers on duty during the day, Principal Officer 4 and Principal Officer 1.

13.47 Principal Officer 4 came on duty at the establishment that morning at 06.43 hours and took on the role of Orderly Officer. Principal Officer 1 came on duty at 07.43 hours and adopted the role of Oscar 3. Slightly later, at 08.13 hours, Governor 5 came on duty and commenced as Duty Governor/Victor 1. Governor 2 came on duty at 08.51 hours as Victor 2. At 09.36 hours that morning Governor 5 and Governor 2 swapped roles, thus Governor 2 now became Duty Governor/Victor 1 and Governor 5 became Victor 2. All of this information is documented in the prison Control Room log. When interviewed by the lead investigator, managers explained that when working a weekend alongside the same colleague it was common practice to swap roles on a daily basis so that key responsibilities were shared out more evenly.

13.48 From the prison records made available to the lead investigator, and from the accounts provided by staff during interviews, there appear to be a number of key questions that remain either unanswered or for which the answers provided failed to add any clarity. First and foremost who, on the afternoon of Saturday the 6th September 2008, when Mr North was assaulted, was actually in command of the prison? Secondly, who was responsible for taking command of what should have been viewed as a critical incident, with the responsibility of ensuring that all of the immediate issues were attended to? The lead investigator has been unable to find the answer to those key questions to his complete satisfaction.

13.49 As if to emphasise the above issue, it is helpful to refer to the remarks made by Governor 5 during her interview with the lead investigator. She explained that Victor 1 is the Duty Governor and responsible for the efficient running of the prison. Victor 2 was described as being the “IC” ‘In Charge Governor’. When pressed on the point of who was actually in charge, was it the Duty Governor or the IC she explained that it would depend on what Grade of staff you had on duty. The normal practice was to have a Grade E and a Grade F Governor on duty, Grade E being higher than F. However on this particular occasion both were Grade E. She explained that in this case, although a technicality, it would probably come down to who had been Grade E for the longest. It was also established that the main reason why they swapped roles on a daily basis was because the Duty Governor (Victor 1) would be responsible for the out of hours on call.

- 13.50 A similar arrangement appeared to exist in relation to the roles of the two Principal Officers, Oscar 1 and Oscar 3. Principal Officer 4 told the lead investigator that Oscar 1 was responsible for running the regime of the prison, in essence making sure that everything ran efficiently. That role was directly accountable to Victor 1, the Duty Governor. He also stated that it was the role of Oscar 1 to attend the scene of any significant incident that took place across the whole prison and to take immediate command of that scene. This was particularly the case in relation to alarm bell activations. As has already been established no alarm bell was activated on this occasion. He clarified that Oscar 1 is most definitely in charge with Oscar 3 in position as a deputy acting in support.
- 13.51 Principal Officer 1 confirmed that Oscar 3 was there very much to support Oscar 1; however in his opinion the role of Oscar 3 had never previously been clearly defined. He described Oscar 1 as very much the incident scene commander.

13.52 The C Wing Collator's log for Saturday the 6th September 2008 shows that at 14.00 hours Victor 1, Governor 2, visited C wing for what is recorded as a routine visit. This would have been shortly after unlocking for afternoon Association, and at around the same time that Mr North was assaulted. Officer 9 stated that shortly after Mr North was found he personally informed Governor 2, the Duty Governor, of the suspicious activity that he had witnessed involving Prisoner 2 and Prisoner 1. Governor 2 however told the lead investigator that he believed that he had left the wing by the time Mr North was found. He also stated that he had no actual recollection of the attack.

13.53 It has been established by speaking with Principal Officer 4 (Oscar 1) that he attended C wing shortly after the incident and from memory he recalled accompanying Mr North from the wing to Healthcare. In addition, again recorded on the collator's log, was a visit to C wing at 14.55 hours by Oscar 3, Principal Officer 1. It was not possible from documentation to establish if his visit to the wing was routine or in any way connected to the assault on Mr North. In subsequent correspondence to the lead investigator Principal Officer 1 stated that his attendance on C wing at that time was in connection with his "*functional*" role and not related to the assault on Mr North.

13.54 Consequently, within a few minutes of Mr North being found injured a number of managers could, and arguably should, have taken responsibility for managing this incident. In reality, it would appear that very little was done to secure evidence and identify the assailants. Senior Officer 4 as Wing Manager, Principal Officer 4 as Oscar 1, Principal Officer 1 as Oscar 3, and ultimately Victor 1, Governor 2, should as a starting point have ordered an immediate lockdown of C wing. Instead, the regime carried on as normal, including prisoners going off the wing to the afternoon gym session. There would appear to be little doubt that this contributed to the ability of prisoners to destroy and conceal any evidence that might have been available, and quite likely had a negative impact upon the subsequent Police investigation that was to follow. The joint Police and Prison Service investigation will be examined in greater detail later in this report.

13.55 The role of Governor 5 has already been discussed earlier in this chapter, particularly around the fact that she was not aware of the assault on Mr North until about an hour after it took place. It would appear that even then she only found out by chance. From her account and from the documentation available, she would appear to have taken reasonable steps at that time to try and retrieve the situation as best she could. She clearly took command of the incident, something that was visibly lacking up to that point. She was quite candid in her account, stating that it is clearly the function of the Duty Governor to take command of such incidents. She explained that the early impetus, quite rightly, had been around Mr North's welfare and getting him out to

hospital safely and securely, but this appears to have been to the total exclusion of all of the other important considerations.

13.56 Prior to going off duty at 18.01 hours that night, Governor 5 sent an internal e-mail timed at 17.43 hours to the Deputy Governor and two other Governors at the prison. The lead investigator is satisfied from the wording and the very existence of the document that she had, as she stated, taken command. In this document she provided a brief resumé of what had happened to Mr North, a brief intelligence summary and noted her concerns that it is possible that this could be part of an escape plan. She also (wrongly) stated that the Police had been informed. The reality was, perhaps genuinely unknown to her, that the Police had only been notified of a Cat A prisoner going out to hospital. She also stated that staff did not find Mr North for 40 minutes, which to be more accurate, was the approximate period of time between unlock and him being found by Officer 10. The precise timing of the assault has never been fully established. She conceded that at the time of writing there was no scene or evidence preservation, no weapons recovered, and the perpetrators had not been identified. In essence, there was no evidence. She recorded the fact that the following day, Sunday the 7th, they would be doing some intelligence-gathering and searching. C wing would be in a state of lockdown.

KEY FINDING 14. HMP Whitemoor failed to conduct any form of investigation into the circumstances of either of the assaults, both resulting in serious injury to

Mr North. In addition, on both occasions, they also failed to preserve the scenes for timely forensic examination or report the incidents to the Police for criminal investigation. The lead investigator sees this as a significant failing by staff at HMP Whitemoor. Although it cannot be judged with any degree of certainty, it is however certainly possible that had the assault in the gymnasium on the 22nd July 2008 been properly managed and investigated, the subsequent attack on the 6th September 2008 may never have taken place.

KEY FINDING 15.

Following the discovery of Mr North in his cell, with significant visible injuries, on the afternoon of Saturday 6th September 2008, he immediately informed the Officers on duty on the wing that he had sustained the injuries as a result of a fall. Officers knew this not to be the case and concluded immediately that he had been badly assaulted. He then continued to give varying accounts as to when, where and how he had sustained his injuries. This may well be attributable to the, now diagnosed, brain trauma.

RECOMMENDATION 1. If it has not already done so, HMP Whitemoor may wish to consider the benefits to be obtained from reviewing internal procedures and guidance for the management, recording and investigation under PSOs 1300, 2700 and 2750 of both prisoner on prisoner assaults and unexplained injuries. It may also be considered appropriate to reinforce any guidance with staff at the establishment in order to ensure an appropriate level of compliance.

RECOMMENDATION 2. If they have not already done so, NOMS and HMP Whitemoor should consider if current procedures and staff training provide for the full and accurate completion of official prison documents. Adequate audit and storage arrangements should also be considered as part of any subsequent review. The investigation highlighted a high number of either incomplete, or missing, official prison records. HMP Whitemoor should consider the policy on retaining both draft and final copies of letters and ensure that a process is in place to readily differentiate between draft and final versions of documents.

RECOMMENDATION 3. If it has not already done so, NOMS should consider the requirement, and benefits to be gained, by reviewing how it responds to managing serious prisoner on prisoner assaults or indeed other critical incidents. Whilst not necessarily exclusive, this review should consider including issues such as command structure, scene and evidence preservation, offender identification and management, plus timely investigations and referral to the Police. There should be absolute clarity at any given time as to who is in command of the prison should a critical incident arise.

RECOMMENDATION 4. If it has not already done so, NOMS should consider the requirement to review, at both national and local levels, protocols and procedures for referring crimes that take place within prisons to the Police, so that all organisations are clear around what is expected of them and the service that will be provided in return.

RECOMMENDATION 6. If it has not already done so, NOMS may wish to consider reviewing its policies and procedures relating to the seizure, recording, retention and continuity of seized items, particularly in respect of critical incidents or where items are likely to be used as evidence in subsequent criminal proceedings.

CHAPTER 14.

POST INCIDENT MANAGEMENT AND INVESTIGATION

- 14.1 The following day, Sunday the 7th September 2008, the same members of the prison management team were on duty. As would appear normal practice, the four members of staff, two Governor Grades and two Principal Officers, swapped roles from the previous day with their respective counterparts. Consequently, as confirmed by the prison Control Room log, Governor 5 was Victor 1, Governor 2 was Victor 2, Principal Officer 1 was Oscar 1 and Principal Officer 4 was Oscar 3. The log also records that at 08.41 hours that morning all residential wings, with the exception of C wing, were unlocked. Albeit somewhat belated, the purpose of the lockdown on that morning was to start the process of evidence-gathering, mainly by means of conducting searches on the wing.
- 14.2 As part of the evidence-gathering process, Officer 13 and Officer 12 finalised the photographing of the interior of Mr North's cell. Upon examination, these photographs clearly depict heavy blood deposits on the floor, furniture, walls, sink and cell door.

14.3 During subsequent searches, a number of items were found and recovered by prison staff. Officer 7, in company with Officer 5, whilst searching the Green 3s showers, recovered a homemade knife, in essence a razor blade melted into a plastic toothbrush. This was described as being secreted under water pipes under the bath. It appeared to be an old weapon that had gone rusty. During the same search of the wing, Officer 5 recovered an almost identical 'knife' in the showers on Red Spur. Again, this implement was old and rusty. Both items were subsequently passed to the Dedicated Search Team staff for recording in the prison seized property register.

14.4 During the same search of C wing, recalling that she had seen Prisoner 2 come from the wing laundry the previous day, Officer 11 carried out a search of the washing machines. During this search she recovered from one of the machines a two-piece, red prison tracksuit that she described as being soaking wet and blood-splattered. The prisoner's personal number that is usually ironed into the garments had also been removed. They were the only items in the machine. Officer 11 subsequently put the items into evidence bags and passed them to members of the Dedicated Search Team. Again, these items are recorded in the prison seized property register.

14.5 Officer 11 informed the lead investigator that, whilst not rigidly enforced, the only prisoners who should be allowed off the spur during Association to go to the laundry were nominated laundry workers. She seemed to recall that at that time Prisoner 2 was a nominated laundry worker. Other staff during interview confirmed that laundry workers would have been active on a Saturday afternoon. Although at the time of interview arrangements had changed to one worker for each spur, at the time of this incident there was just one for each residential wing. It was also stated that the wing laundry was only intended for prisoners' personal items and that any prison-issue kit, such as tracksuits, should go to the main prison laundry.

14.6 During the morning of Sunday the 7th September 2008 more information began to emerge regarding the seriousness of the injuries sustained by Mr North during the events of the previous day. There are a number of entries that relate to this in the prison Control Room log. At 09.31 hours Officer 15 at Hospital 1 notified the prison that Mr North had now had a brain scan which confirmed he had bleeding on the brain. At 11.19 hours Officer 15 spoke with Governor 5 and notified her that Mr North had a cracked skull and bleeding on the brain and that his condition was considered potentially life-threatening. It was shortly after this call, at 11.30 hours, that Mr North was transferred to Hospital 2, together with a Police escort, arriving at 12.04 hours. The prison log also records that at 11.19 hours Governor 4, in his capacity as Head of Security, was updated regarding developments.

- 14.7 On the morning of Sunday the 7th September 2008 the Duty Officer in the Cambridgeshire Constabulary Control Room was Police Inspector 1. Police Inspector 1 was subsequently interviewed by the lead investigator as part of this Article 2 investigation. Police Inspector 1 confirmed that he was not on duty the previous day, Saturday the 6th. However, he did confirm that all entries made on the 6th September on the Police Command & Control Log, related to dialogue between the Police and HMP Whitemoor, following a request by the prison for assistance with security arrangements connected to Mr North's transfer out of the prison to an external hospital. There was no reference to the investigation of any criminal offences potentially arising out of this incident.
- 14.8 Police Inspector 1 stated that he subsequently became involved in similar dialogue, around security arrangements, with the prison on the morning of Sunday the 7th September in relation to Mr North's transfer from Hospital 1 to Hospital 2. He recognised that nothing appeared to be happening around any sort of investigation into how Mr North had received such serious injuries. Consequently, it was Police Inspector 1 who then initiated a sequence of events that focused on the injuries sustained by Mr North, how they were inflicted and the likely requirement for a criminal investigation.
- 14.9 There is an entry on the Police Control Room log which is auto-timed at 11.26 hours which states that PC 2, Prison Intelligence, was made aware and he would make some enquiries. Unbeknown to Police Inspector 1, PC 2 was no longer the Police Intelligence Officer at HMP Whitemoor.

He had moved to a new post in 2007 and had been replaced by PC 1. That said, and to the immense credit of PC 2, who was off duty at home, he immediately telephoned HMP Whitemoor to establish how Mr North had sustained his injuries, what action the prison was taking, and what was required, if anything, of the Police.

- 14.10 There is a subsequent entry on the prison Control Room log timed at 11.30 hours that states that the Cambridgeshire Police PLO called into the prison (now known to be a phone call) and had been updated on the general risk of the situation with the North escort. For clarity, the aforementioned phone call was not actually from the then current PLO, PC 1; it was actually from his predecessor, PC 2. This entry would tend to suggest that even at this stage of events the mindset of prison staff was still solely focused on security matters and not on any criminal investigation by the Police. PC 2 recalled that he received this update direct from Governor 5 and he then updated Police Inspector 1.

- 14.11 Some eleven minutes after the aforementioned call between the prison and PC 2, Police Inspector 1 recorded on the Police log that he had received an update from the prison via PC 2, and it had been confirmed that the prisoner had been seriously assaulted. The prison had stated that they had secured the cell of the prisoner whom they suspected of having committed the assault. Police Inspector 1 also recorded the fact that he had informed the on duty Central Detective Sergeant who would initiate an investigation at the prison.
- 14.12 Subsequent enquiries by the lead investigator have concluded that the aforementioned Police Control Room log (Sunday the 7th September) actually contains a slight inaccuracy. It is believed that the entry should read that the prison had actually secured the cell of the victim (Mr North) and not the suspected perpetrator(s). This is because as far as can be established, at the time of that telephone call between Governor 5 and PC 2 no action had actually been taken regarding the identification of possible suspects.
- 14.13 Almost immediately after receiving this update from PC 2, Police Inspector 1 telephoned HMP Whitemoor and spoke personally with Governor 5. The prison Control Room log records this call as being at 11.53 hours. The accounts of events given by Police Inspector 1 and Governor 5 around the content of this call are somewhat different. Police Inspector 1 was clear that he made the contact with the prison in order to speak to Governor 5 and that the conversation was again around the security of Mr North whilst at hospital, particularly in light of the fact that

his family now knew where he was as they had been given permission to visit. Police Inspector 1 reiterated that there was no request at this point from the prison for a Police investigation into the assault on Mr North.

- 14.14 Conversely, Governor 5 told the lead investigator that she was quite annoyed that the Police Liaison Officer, PC 1, hadn't been in contact with the Prison in response to the voicemail messages that had been left for him on his mobile phone. She was of the view that it was she who had in fact initiated the aforementioned telephone conversation with Police Inspector 1. She couldn't fully recall if she had rung him direct or if she had requested the prison Control Room to get hold of him on her behalf. She did say that she was pretty annoyed at the lack of response by the Police, and had quite a direct conversation with Police Inspector 1, as she had assumed that they would commence an investigation as a consequence of the initial contact with them when Mr North went out to hospital on the afternoon of Saturday the 6th September. Governor 5 considered that the misunderstanding may have arisen as a consequence of both parties initially not fully appreciating the severity of the injuries sustained by Mr North.

- 14.15 Without exception, all Police Officers interviewed as part of this investigation are of the firmly-held opinion that staff at HMP Whitemoor should have reported the assault to the Police much earlier than actually happened. Even allowing for the fact that the full extent of the injuries sustained by Mr North did not become fully clear until sometime afterwards, it should have been apparent as early as the Saturday afternoon, even prior to him going out to Hospital 3 for treatment, that this was a serious attack involving a number of prisoners and the use of weapons. It appears from the prison Control Room log that there were a number of early attempts to make contact with the Police Liaison Officer, PC 1, presumably with the intention of him triggering a Police investigation. It would appear that there was an over-reliance on this being the sole means of engaging with the Police.
- 14.16 It would appear that during the period when PC 2 was the Police Liaison Officer at HMP Whitemoor, he was prepared to be available to take calls for assistance 24 hours a day, seven days a week. He had no obligation to work to these arrangements and did so out of personal choice. When replaced by PC 1, the working arrangements changed in that PC 1 worked his 40-hour week pretty much Monday to Friday, switching off his mobile phone at weekends which were his nominated rest days. It was quite clear from interviews with a number of Governor Grade staff at Whitemoor that they were unhappy with this arrangement and generally expected PC 1, like PC 2, to be available, within reason, 24/7.

- 14.17 PC 1 confirmed to the lead investigator that when off duty his mobile phone was switched off. Given the attack on Mr North happened on a Saturday afternoon, he did not pick up the messages left for him until he switched the phone on again on the following Monday morning, 8th September. He was of the firmly-held view that the management at the prison knew that he was not on call out of core hours and that anything urgent should be reported straight into the Police Control Room. Again, conversely, Governor 5 was of the opinion that the general agreement was that the first point of contact for such matters was supposed to be the Police Liaison Officer.
- 14.18 At approximately 12.00 midday on Sunday the 7th September 2008, in addition to his dialogue with Police Inspector 1, PC 2 also made a telephone call to Detective Chief Inspector 1. Detective Chief Inspector 1 was Head of Cambridgeshire Constabulary Major Investigation Team (MIT) and was also the on call Senior Investigating Officer (SIO) that weekend. It is clear that PC 2 made this call in light of the information available to him around the extent of the injuries sustained by Mr North. As a consequence of this phone call, Detective Chief Inspector 1 immediately took command of the incident from a policing perspective and launched a full criminal investigation.
- 14.19 During interview with the lead investigator, Detective Chief Inspector 1 produced a copy of his SIO notebook and recounted the telephone conversation with PC 2. He has made a contemporaneous note of that call commencing at 12.00 midday. In discussion with PC 2, he recalled

questioning why, based upon the briefing he was given, the prison had not called the Police earlier. He also agreed that, having reviewed the Police Control Room logs, the intervention of Police Inspector 1 at 11.26 hours on Sunday the 7th September 2008 was the very first recognition that an investigation was necessary.

14.20 Whilst there are some differences in opinion and interpretation between the Police and the prison on who should have done what and when, it is clear that there was a considerable delay between Mr North being assaulted and the Police investigation commencing. It cannot be judged with any degree of certainty what, if any, impact this had on the subsequent Police investigation. The Police are quite clear in that the early engagement with them from the Prison was all around the security of Mr North (a Cat A prisoner) whilst away from the prison at hospital. Had they had the assault reported to them, or indeed been briefed on the extent of his injuries, then an investigation would have been commenced much sooner. As has already been mentioned, the Prison appeared over-reliant on the PLO alone as their sole means of reporting the matter to the Police. Clearly, there was the other option of reporting the incident direct to the Police Control Room once a short period of time had passed and the PLO had not responded to messages left for him. In addition, in the opinion of the lead investigator it would appear that an assumption had been made that because there had been dialogue with the Police around the ongoing security of Mr North an investigation would automatically be instigated by Cambridgeshire Constabulary.

- 14.21 Unfortunately it would appear that, in addition to the poor management of the crime scene and lack of attempts to quickly identify the perpetrators, early notification to the Police to ensure their engagement was not properly gripped by the on duty managers at HMP Whitemoor. Governor 2, who was Victor 1 on the afternoon of the attack, could not actually recall the incident at all when spoken to by the lead investigator. In the opinion of the lead investigator, given the severity of Mr North's injuries and events that then followed, this appeared somewhat strange. Governor 2 appeared to display a clear lack of understanding around what was required of him in these circumstances.
- 14.22 Thankfully, Mr North's injuries did not prove to be fatal as was thought to be a possibility at one stage. Had he not made a recovery, then the lack of action by staff at HMP Whitemoor on the afternoon of Saturday the 6th September and into Sunday the 7th September could have been the source of far greater embarrassment for NOMS.
- 14.23 As a result of what staff had observed and documented in Security Information Reports (SIRs), strengthened by entries in the Wing Observations Book, two prisoners from C wing Green Spur, Prisoner 2 and Prisoner 1, were identified as suspects for the attack on Mr North on the afternoon of Saturday the 6th September. In essence, Prisoner 2 and Prisoner 1 emerged as suspects as a result of events involving them immediately after the assault. What remains somewhat unclear is why they were not identified as suspects, and any evidence secured, much earlier than appears to have been the case. Clearly, nothing was done

in relation to this on the Saturday and who did what and when on the Sunday, over and above some wing searches, cannot be readily established. What is clear is that again going into the Sunday it was Governor 5 who had assumed command of the incident from a prison perspective. This is clearly evidenced via her dialogue with Police Inspector 1 and was also confirmed by Detective Chief Inspector 1 when he arrived at the prison with his team at approximately 16.30 hours on the Sunday afternoon.

14.24 Some additional information, recorded on SIRs dated the 7th September, was received suggesting that Mr North had been attacked by up to seven Muslim prisoners and that he had been kicked and punched and that blades were used. The information also suggested that he had been in a long-standing dispute with some Muslim prisoners as a result of an attack which he had carried out whilst at HMP Full Sutton and that the problem had followed him to Whitemoor. Involvement in any assault at HMP Full Sutton, when put to Mr North, was something that he categorically denied.

14.25 It should be made clear for the purposes of this report that the Terms of Reference for this Article 2 Investigation do not include examining the role of Cambridgeshire Constabulary or their subsequent Criminal Investigation into the assaults on Mr North. What has been examined by the lead investigator, part of which has already been covered earlier in this report, is the interface between HMP Whitemoor and the Police. Primarily, this extended to how the offence on the 6th September was

reported by prison staff to the Police and the prison's initial engagement with the Police upon their arrival at the establishment later that day. The investigation also examined their subsequent support to the criminal investigation.

- 14.26 Returning to the Police Control Room log for Sunday the 7th September 2008, there is an update from the prison, via PC 2, stating that Mr North's injuries were not now thought to be life-threatening. It also stated that he would be monitored for 24 hours but was not likely to need surgery. This entry is timed at 13.15 hours.

- 14.27 At 15.15 hours that afternoon DC 1 from Cambridgeshire Constabulary Major Investigation Team spoke with Mr North at Hospital 2. Prior to speaking with Mr North he had sought, and been given, permission to do so by the duty Registrar who had stated that Mr North was only there for observations. DC 1 told the lead investigator that he was surprised by Mr North's outward appearance and demeanour. He stated that he did not present as might have been expected, given that only a short time previously his injuries were described as being life-threatening. Whilst polite, Mr North was somewhat less than co-operative, telling DC 1 that he had sustained his injuries as a result of an accident, a misunderstanding, and he didn't want to be going to court. This comment may have been prompted of course as a consequence of the brain injury that he is now known to have sustained.
- 14.28 At 16.30 hours on the afternoon of Sunday the 7th September 2008 a briefing between Governor 5 and Detective Chief Inspector 1, plus their respective team members, was held at HMP Whitemoor.

- 14.29 During his interview with the lead investigator Detective Chief Inspector 1, referring to his Police Log notes, stated that at 17.15 hours that evening he requested, based upon the information made available to him, that Prisoner 2 and Prisoner 1 be segregated on suspicion of being involved in the attack on Mr North. This was in order to secure and preserve any evidence that may still be available. This request was actioned by the prison immediately, the process being completed by approximately 17.43 hours. This is fully recorded in both the Movements Log and Control Room log. Given that there was also the outline of a visible footprint in blood on the floor of Mr North's cell, at 18.15 hours that night Detective Chief Inspector 1 made a policy decision to request the seizure of all footwear from the prisoners located on Green Spur. The prison agreed to this request and this aspect of the investigation will be covered later in this chapter.
- 14.30 Detective Chief Inspector 1 told the lead investigator that following his arrival at the prison he was assured by Governor 5 of the full co-operation and support of the Prison Service, which he indeed received. In his opinion this forthright statement of support was partly informed by the fact that Prison Managers were very alive to the fact that their actions around this incident were, at some point, likely to be examined and they were already sensitive to the possibility of liability and criticism.
- 14.31 When reflecting on the 26 hours that elapsed between the assault on Mr North and his arrival at the prison to commence the investigation, Detective Chief Inspector 1 readily concluded that the prison

management probably could and should have done more and much quicker. In particular they should have recognised the severity of the attack on Mr North and immediately moved to a secure and preserve mode in relation to the scene and any other available evidence. As a minimum, Green Spur should have been locked down and the Police informed immediately.

14.32 Once it became clearer that the injuries were not likely to prove fatal Detective Chief Inspector 1, in accordance with established Police working practices, handed the investigation back to Divisional CID under the command of Police Inspector 2. It is believed that this handover took place on Monday the 8th September 2008.

14.33 On the morning of Monday the 8th September 2008 all residential wings at HMP Whitemoor remained in a state of lockdown for slightly beyond the normal time for unlock. This was to allow for extra staff to be available on C wing Green Spur in order to assist with the co-ordinated seizure of footwear from all prisoners that remained on the spur. The footwear of Prisoner 2 and Prisoner 1 had already been recovered by this time.

14.34 Although again co-ordinated by Governor 5, Principal Officer 2 (Acting) actually managed the operation to recover the footwear from a tactical perspective. He briefed all of the staff and allocated two Prison Officers to each occupied cell on the spur. Just after 08.00 hours that morning Principal Officer 2 (Acting) blew a whistle, at which point each cell was

entered simultaneously by prison staff and all footwear recovered and forensically packaged. These searches were all completed by approximately 08.30 hours. Once correctly packaged, the recovered footwear was all handed to staff on the Dedicated Search Team for entry in the seized property register.

14.35 On Tuesday the 9th September 2008 cell G1-035, occupied by Prisoner 1, and cell G3-034, occupied by Prisoner 2, were the subject of a joint search for evidence by Police and prison staff. Items of clothing were removed from both cells for forensic examination. On that same day all of the property recovered as a result of this investigation and entered into the prison seized property register was formally handed over to the Police, against signature, by Senior Officer 6. During interview with the lead investigator, Senior Officer 6 went through the entries in the prison seized property register. He confirmed that any evidence recovered from across the entire prison was recorded in this single register. Consequently, entries from this investigation were mixed up with items from other seizures in terms of how they were recorded. The lead investigator noted that the entries contained the minimum of information which made it difficult for all concerned to actually identify what did, and didn't, relate to the North investigation. The property seized column generally only contained the briefest of descriptions of the items. There were no details required of who recovered items, from where and when.

14.36 Senior Officer 6 explained that this type of information would generally be recorded on the individual property label that is actually attached to

an item. He also confirmed that it was not general practice to use a separate exhibits register when numerous items are seized as part of one search/operation/investigation.

14.37 Over the course of the days that followed the Police and prison remained in close dialogue in respect of the ongoing investigation. On Tuesday the 9th September 2008, C wing remained in a state of lockdown. Likewise, Prisoner 2 and Prisoner 1 remained located within the Segregation Unit. They remained there for some time in order to allow for the completion of Police enquiries. As would be normal post-event, there were some small items of intelligence from across the prison that found their way into the Security department. This new information, including the naming of suspects, was not of sufficient detail or reliability as to make any meaningful impact on the Police investigation. More importantly, no witnesses from amongst the other prisoners on Green Spur came forward to talk to the Police.

14.38 As part of the Police investigation both Prisoner 2 and Prisoner 1 were interviewed under caution. Neither man spoke in response to the questions asked. Prisoner 2 subsequently told the lead investigator that he knew Prisoner 1 but he (Prisoner 1) was nothing to do with the assault on Mr North. He further stated that he had no idea why either of them had been segregated on suspicion of being involved in the attack on Mr North.

14.39 Whilst forensic examination of some of the items seized by Police as part of the criminal investigation provided some evidence to link Prisoner 2 with the scene, the Crown Prosecution Service, even after considering the evidence on three occasions, chose not to pursue a prosecution against him. In their professional judgement it did not meet the 'sufficiency of evidence test'. In essence, they were unlikely to gain a conviction at court based on the available evidence. Prisoner 2 told the lead investigator that the reason that there was some evidence to link him forensically to Mr North's cell at the time of the attack was because he had actually gone inside in order to break up the fight. He considered that he had helped minimise the injuries sustained by Mr North.

- 14.40 In an extract from the minutes of the HMP Whitemoor IMB Board Meeting held on the 9th September 2008, it was noted that the Governor briefed those present on recent events involving the attack on Mr North. The Board Chair, having heard the account provided, stated that the IMB had not, up to that point, been made aware of this incident when clearly they should be notified of such events immediately in order for them to discharge their obligations in an efficient and timely manner.
- 14.41 The lead investigator would echo the words of the Board Chair and see it as a failing of process that the IMB was not notified about a very serious assault on a prisoner until some three days after the event. This very clearly impacted upon the IMB's ability to discharge its function.
- 14.42 As part of the investigation into the events of the 6th September 2008 Cambridgeshire Constabulary also investigated the earlier attack on Mr North in the gymnasium at HMP Whitemoor on the 22nd July 2008. That aspect of the investigation also failed to result in the identification and prosecution of the offenders. In fairness to the Police, given the lapse in time and the environment in which they were operating, that is not surprising.

- 14.43 The attack in the gymnasium was subsequently recorded as an offence of Grievous Bodily Harm, contrary to Section 20 Offences Against Person Act 1861, not as attempted murder as has previously been suggested. The attack on the 6th September was recorded as an offence of Wounding with Intent, contrary to Section 18 Offences Against Person Act 1861.
- 14.44 In a post-investigation debrief with the lead investigator, the subsequent Senior Investigating Officer, Police Inspector 2 (by that time a Detective Chief Inspector) expressed an opinion that there were some weaknesses in HMP Whitemoor's approach to this incident, particularly in that it should have been reported to the Police for investigation immediately on the 6th September. Police Inspector 2 stated that she was not in a position to judge with any certainty if this had impacted upon the eventual outcome of the enquiry. She was firmly of the view that the delay in reporting was a process failing in itself on the part of the prison.
- 14.45 The role of Governor 5 has been the subject of much comment in this report. It would appear clear that once she became aware of the attack on Mr North she took action to grip what needed to be done and demonstrated a willingness to own the incident pretty much through until its conclusion. It is clear that she felt somewhat angry and let down by the initial failings of others, particularly in the golden hour when potential opportunities to secure evidence and identify offenders were lost. She made available to the lead investigator several pages of rough notes that she had made using standard loose-leaf lined paper. Similar to

Governor 4 when he was recording his risk assessment around the transfer of Mr North from the Segregation Unit, Governor 5 may well have benefited, had she had available to her, a formal bound note book, perhaps containing a short aide-mémoire about the sort of issues to consider and record when confronted with a serious or critical incident. Such books are readily available to, and used by Police Officers, as part of their work on significant investigations / incidents. NOMS may wish to consider whether the introduction and use of such notebooks would be of benefit to individuals and its prisons in general.

- 14.46 By way of concluding this chapter of the report the lead investigator would like to re-emphasise the point that one of the two individuals segregated on suspicion of being involved in the attack on Mr North on Saturday the 6th September 2008 was Prisoner 1. Enquiries have established that on C wing Green Spur Prisoner 1 was located in cell G1-035, only two doors away from Mr North in cell G1-033. Whilst covered in greater detail elsewhere in this report, it is worth repeating that during his second interview with the lead investigator Mr North informed him that he had been in a position to identify his attackers immediately afterwards to staff in the gymnasium on the 22nd July 2008 but made a conscious decision not to do so. He subsequently altered that account somewhat, stating that no prison staff ever asked him to do so and in any event he would not want the stigma as being seen as a grass by other prisoners. On a number of occasions Mr North made a conscious decision not to cooperate with the very prison staff that were charged with the task of managing any risk to his welfare. He states that

he believed that staff at HMP Whitemoor already knew the identity of his attackers as, in his opinion, they know everything. This is clearly not correct; the Prison Service was not aware of that information. If prison staff had known of the potential involvement of Prisoner 1 in the assault on the 22nd July in the gymnasium, then clearly they would not have taken the decision to locate him only two cells away from his assailant when transferred from Segregation to C wing on the 6th September. The lead investigator cannot separate Mr North's lack of cooperation and honesty from the subsequent chain of events that sadly resulted in the second attack on him. Had he chosen to cooperate with prison managers and assist with identifying his assailants, then the outcome is likely to have been somewhat different, in that the assault on the 6th September might not have happened.

14.47 The role of Legal Practice 1 in this case has already been the subject of comment by the lead investigator. In particular he has some concerns about their style of communication with the prison prior to the decision to release Mr North from Segregation back to the wing. It would not be inappropriate to at least question whether they always acted in the best interests of their client or exercised appropriate levels of diligence given the potential threat to his welfare. On the 11th September 2008, five days after the second attack, the prison received a further letter from Legal Practitioner 1 at the practice. Again, this was a most forthright and demanding letter insisting that the prison immediately provide them with certain information and that any failure to do so would leave them with no option but to contact the Ministry of Justice. It has been established

that Legal Practitioner 1 was only a trainee solicitor, working to Solicitor 1, with no authority to act independently of him. Whilst the role of Legal Practice 1 in this case does not form part of the Terms of Reference for this investigation, it is difficult not to consider what impact, if indeed any, their involvement actually had on decisions made by HMP Whitemoor in relation to the management of Mr North. They may just want to reflect on their style of communication and how they represented the interests of their client. In the lead investigator's opinion they have simply attempted to apportion blame on the Prison Service at all stages of the proceedings without ever considering their personal responsibilities and accountabilities. Quite rightly, in the opinion of the lead investigator, given the tone and content of the letter of the 11th September, HMP Whitemoor declined to engage further on this matter.

KEY FINDING 16.

There did not appear to be an established procedure at HMP Whitemoor whereby the Police were notified of serious crimes taking place within the establishment. Staff were unclear as to who in the prison was responsible for that decision and taking action. In addition, there appeared little recognition by many staff of the requirement to act promptly in order to secure and preserve evidence, and the need for early identification and management of suspects.

KEY FINDING 17.

In the opinion of the lead investigator, two key questions remain unanswered. First and foremost, who on the afternoon of Saturday 6th September 2008 was actually in command of HMP Whitemoor? Secondly, who was responsible for taking command of the aforementioned incident that afternoon? This was a serious assault, and should have been recognised and managed as such, from the very outset. Unfortunately, that appears not to have been the case.

KEY FINDING 18.

All of the available evidence suggests that it was Police Inspector 1, duty officer in

Cambridgeshire Police Control Room, who first recognised the need for a criminal investigation into how Mr North received his injuries. This didn't happen until very late morning on Sunday 7th September 2008. The reality is that staff at HMP Whitemoor should have taken steps to secure a Police investigation into this matter much earlier. It cannot be judged with any degree of certainty what, if any, impact this delay had on the Police investigation that followed. The prison appeared to be over-reliant on using the Police Intelligence Officer at the prison as the sole mechanism for reporting the incident to the Police. In his absence a conventional call to the force Control Room would have been appropriate.

KEY FINDING 19.

Virtually every member of prison staff interviewed as part of this investigation, regardless of grade, expressed their surprise that the wing (C wing), or as an absolute minimum Green Spur, was not the subject of an immediate lockdown after the assault on Mr North on the 6th September 2008. This course of action would have assisted greatly with the tasks of identifying offenders and securing any available evidence. There would appear little doubt that this contributed to the ability of prisoners to destroy or conceal any evidence that may have been available to support both criminal and internal investigations.

RECOMMENDATION 3.

If it has not already done so, NOMS should consider the requirement, and benefits to be gained, by reviewing how it responds to managing serious prisoner on prisoner assaults or indeed other critical incidents. Whilst not necessarily exclusive, this review should consider including issues such as command structure, scene and evidence preservation, offender identification and management, plus timely investigations and referral to the Police. There should be absolute clarity at any given

time as to who is in command of the prison should a critical incident arise.

RECOMMENDATION 4. If it has not already done so, NOMS should consider the requirement to review, at both national and local levels, protocols and procedures for referring crimes that take place within prisons to the Police, so that all organisations are clear around what is expected of them and the service that will be provided in return.

RECOMMENDATION 6. If it has not already done so, NOMS may wish to consider reviewing its policies and procedures relating to the seizure, recording, retention and continuity of seized items, particularly in respect of critical incidents or where items are likely to be used as evidence in subsequent criminal proceedings.

RECOMMENDATION 7. NOMS may wish to consider whether the introduction and use of bespoke bound notebooks would be appropriate for use by personnel engaged in the management of serious or critical incidents. Similar documents are in use in other organisations for the purpose of recording, in one place, notes, thought processes and subsequent decisions.

RECOMMENDATION 8. If it has not already done so, staff at HMP Whitemoor may wish to consider reviewing local procedures for the early notification of significant incidents or events to the Independent Monitoring Board.

CHAPTER 15.

RELEASE FROM HOSPITAL AND TRANSFER TO PRISON 1

- 15.1 Following his readmission to hospital on Sunday the 7th September 2008, Mr North subsequently remained as an inpatient at Hospital 2 through until the 3rd October 2008. He was then discharged back into the care of staff at HMP Whitemoor.
- 15.2 Prior to this discharge there had been a previous attempt to return him to the prison on or around the 24th September 2008. However, due to a deterioration in his medical condition and the ongoing concerns of staff at Hospital 2, that course of action was aborted and it was decided that for the time being he would remain in hospital.
- 15.3 Following his subsequent return to the prison Mr North continued to receive medical supervision and treatment via Healthcare staff at HMP Whitemoor. Details of his medical diagnosis and treatment are the subject of separate detailed commentary in Chapter 16.
- 15.4 However, on the 18th November 2008, due to his prevailing medical condition Mr North was again transferred from HMP Whitemoor back to Hospital 3. He remained there as an inpatient through until the 2nd December 2008 when he was again discharged and returned to prison.
- 15.5 Post the assault on Mr North on the 6th September, IMB records show that he was seen by its members on numerous occasions whilst resident

in the prison Healthcare Centre. There was no evidence to suggest that Mr North was visited by a member of IMB during his lengthy periods of residence in hospital. This is not seen as a criticism but more as an observation. The lead investigator is unclear if, in such circumstances, a visit to an external setting in order to discharge its function would normally be undertaken. If not, then perhaps it is a matter worthy of further consideration and assessment.

15.6 Mr North remained located in the Healthcare Centre at HMP Whitemoor until the 17th December 2008 when he was then transferred to the Healthcare Centre at Prison 1. At the time of this investigation Mr North remained resident within that unit.

15.7 On the 29th September 2009, despite his ongoing medical condition, Mr North was charged under Prison Rules with an offence of having in his possession unauthorised articles, or a greater quantity of any articles, than he is authorised to have. At a subsequent adjudication hearing on the 1st October 2009 the allegation was found 'Proven'.

15.8 On the 6th January 2010, whilst in the Healthcare Centre at Prison 1, Mr North was the victim of a further assault by another prisoner. In a statement made by Mr North he describes how on this occasion he was sitting down drinking a cup of coffee when the prisoner came up behind him and struck him on the head with a broom handle, breaking it in the process. He stated that it was a completely unprovoked attack which he found “*quite shocking*”, and this made him feel much more unsafe. Mr North further stated that the prisoner was Muslim and as far as he was aware was new to the prison “*from the street*”.

15.9 As a result of this attack Mr North was examined by Healthcare staff and found to have a contusion to the top of his head but the skin was not broken. He was described by staff as being fully orientated and able to walk back to his cell. The doctor treating him recorded that there had been a blow to the frontal bone of the scalp area and that there was a lump over the site of the assault. The record concluded that there were “*No symptoms reported*”. He was subsequently observed every two hours until lockdown and then every four hours thereafter. It was recorded that Mr North declined to pursue the matter further.

- 15.10 During a subsequent interview with the lead investigator Mr North stated that he had been in conversations about the Muslim faith with his assailant during the days prior to the assault. Mr North stated that he had told this individual that he (the assailant) wasn't a proper Muslim as he ate bacon. Mr North suspects that the assault probably evolved from those conversations. It transpires, both from what Mr North stated and enquiries with the prison, that his assailant on this occasion was subsequently transferred to hospital for psychiatric treatment.
- 15.11 From all of the information available there is no intelligence or evidence to suggest that this attack was in any way connected to previous assaults on Mr North or his apparent, ongoing dispute with Muslim prisoners.

RECOMMENDATION 9. Independent Monitoring Boards across NOMS may wish to consider the merits or otherwise of visiting prisoners whilst they are temporarily resident in external settings such as hospitals. This could be particularly relevant if a prisoner is absent from the prison for a protracted period of time.

CHAPTER 16.

MEDICAL ASSESSMENT, TREATMENT AND PROGNOSIS

16.1 As mentioned earlier in this report, Professor 1, Consultant Neurologist, was appointed as Medical Advisor to Mr North and his legal representatives. Dr Louis A Loizou, Consultant Neurologist, was appointed to act as Independent Medical Advisor to the Lead Investigator Mr Kevin Bradford. Both Professor 1 and Dr Loizou had access to copies of Mr North's medical records. These are referred to in some detail at the relevant part of their respective reports. Both Professor 1 and Dr Loizou have carried out medical examinations on Mr North.

16.2 In essence, both Professor 1 and Dr Loizou provided expert opinion in relation to Mr North's health and medical history prior to him being assaulted at HMP Whitemoor in 2008, the injuries sustained and medical treatment administered as a consequence of the assaults, his current medical condition and his medium to long-term prognosis. It is worth noting, at this point, that the evidence of Professor 1 is consistent with that of Dr Loizou. There are no significant differences with regard to their findings or opinions.

- 16.3 Both Professor 1 and Dr Loizou report that Mr North did not appear to have any significant underlying health or medical problems prior to the assaults in HMP Whitemoor on the 22nd July and the 6th September 2008.
- 16.4 In Professor 1's medical report dated 28th July 2010, he states that Mr North had informed him that as far as he could recall he had no significant past medical history. He notes an x-ray report from the 16th September 2004, which showed a complete rupture of the anterior cruciate ligament of his left knee. This was an MRI scan undertaken two years after a twisting injury to the left knee.
- 16.5 The National Health Service was involved in a telephone consultation on or around the 4th October 2004 when Mr North had a headache. Paracetamol was recommended. A past medical history records tension headaches in June 2005, hearing loss on the 2nd December 2005 and lower back pain on the 13th April 2006. He was seen on 2nd December 2005 by Consultant 1, Consultant ENT Surgeon, in relation to his hearing loss. No significant abnormality was found.
- 16.6 He was seen medically when he set fire to his cell on the 4th January 2006, but it was established that he suffered no significant harm.
- 16.7 His prison medical records contain detail of many occasions when he had been the subject of use of force. He does not appear to have suffered any significant permanent injuries as a result of these incidents.

- 16.8 Within Dr Loizou's reports, he very much concurs with the aforementioned findings of Professor 1 with regards to the medical history of Mr North. He also refers to historical problems with knee pain, backache, sciatica and the diagnosis of tension headaches in 2005.
- 16.9 It is concluded that with the exception of the usual level of minor illnesses and ailments, Mr North was active and living a healthy existence within the usual constraints of the prison environment, prior to him being assaulted on the 6th September 2008.
- 16.10 Professor 1 first examined Mr North on the 22nd December 2008 in Prison 1. Following on from that examination, Professor 1 then produced a comprehensive medico-legal report dated 30th December 2008. He makes it clear at the start of his report that the content is based upon his examination of Mr North, and access to copies of medical records from Hospital 2.

- 16.11 Professor 1 also confirms that within the medical record that he has seen there is a front sheet from the Accident and Emergency Department at NHS Trust 2 showing that Mr North arrived at 17.17 hours on the 6th September, having been transferred by an ambulance from HMP Whitemoor.
- 16.12 This record shows that when first seen by staff at the hospital Mr North's blood pressure was 110/60. The record also states that he "*Presented with head injuries, slash and puncture wounds around ears and back of head of varying sizes and depth.*" There were lacerations to both wrists and anterior aspect, defence wounds to his hands and between the fingers. The doctor wrote, "*Possibly assaulted by inmate. Patient denies this and says that it was a fall from a bench.*" Clinically he was noted to have slurred speech, confusion and constricted and non-reactive pupils.
- 16.13 Some of his multiple head lacerations were glued. Sutures were used for others. Given that he was considered High Risk in security terms, he was allowed to return to HMP Whitemoor for further observation.

- 16.14 At 06.28 hours on Sunday the 7th September 2008, Mr North attended the Accident and Emergency Department at Hospital 1, having again been transferred from HMP Whitemoor by emergency ambulance. At this time his pulse was 50, blood pressure 176/63 and his temperature was not recorded. A CT brain scan showed an intra-cerebral haemorrhage extending into the internal capsule and into the right ventricle. It also showed a fracture of the right temporal bone (i.e. the skull on the right). There was underlying intra-parenchymal blood in the perisylvian region extending to the lateral ventricle. There was blood in the fourth ventricle. The temporal horns were mildly dilated. In other words he had bleeding on the brain.
- 16.15 On arrival he was noted to be “*Displaying various levels of consciousness – unclear whether this is real or not.*” He was not cooperative.
- 16.16 Later that day, the 7th September, Mr North was transferred to Hospital 2 where he was admitted under the care of Consultant 2, Consultant Neurosurgeon. When first seen there by medical staff at 12.30 hours, he was obeying commands promptly, and there was no focal motor loss. He was admitted for observation.

- 16.17 On Monday the 8th September Mr North had a CT angiogram of his cerebral circulation. This showed a haematoma in the right frontal lobe and the depressed fracture of the right temporal bone. There was no evidence of an aneurysm in the right middle cerebral artery, and his vasculature was normal. At 17.20 hours that same day he was noted to be in post-traumatic amnesia.
- 16.18 On the 9th September he was still disorientated in time and place, and on the 10th September he was still amnesic. On the 11th September he had a further CT brain scan which showed no significant changes.
- 16.19 By the following day, 12th September, he was considered fit enough to return to the prison, but after further discussion he was kept for further observation. He was still in post-traumatic amnesia.
- 16.20 On the 13th September it was noted, "*Getting weaker on his feet.*" On the 14th September he was started on olanzapine, an anti-psychotic major tranquillizer. On the 15th September it was noted "*Disorientated in place. Thinks he is in prison. Personality change after injury.*" By the 18th September it was noted "*Memory et cetera, slowly improving.*"
- 16.21 On the 19th September he was sufficiently well recovered to strike a Prison Officer on the head, however, it was noted that he was not eating or drinking. He was also said to be confused and inappropriate.

- 16.22 On the 22nd he was said to be feeling fine, but not to be mobilising and he was complaining of leg weakness. Although transfer back to prison was discussed, there were concerns that he was not sufficiently fit. The following day he was still in post-traumatic amnesia and confused. Again, there were further discussions about possible transfer. Mr North's physiotherapist wrote "*AOI required for bed to chair transfers.*" Professor 1's assumption is that AOI means "*assistance of one.*"
- 16.23 On the 24th September it was noted that Mr North's blood pressure had dropped to 90 systolic, his pulse was about 70 and his body temperature was 34.5 degrees centigrade. Later that day it was noted that his sodium was 162, his urea was raised and his platelet count reduced. It dropped as low as 56.
- 16.24 The next day, the 25th September, it was noted that his sodium was 164, potassium 3.8, urea 15.4, creatinine 139, serum osmolality 349 and urine osmolality 1053. He was encouraged to drink more. His core temperature remained low at 34 degrees centigrade. Later on that day he was noted to have a sinus bradycardia of 50, and J waves were seen on his ECG. Hypo-pituitarism was suspected. He was therefore reviewed by an endocrinologist. This person noted the hypernatraemia and the hypothermia and that Mr North was confused. The impression was that he was dehydrated, and that there was not anything to suggest diabetes insipidus or hypo-adrenalism.

- 16.25 Later, on the 25th, Mr North was admitted to the Neuro-Intensive Care Unit for observation. The impression appeared to be that he was confused, refusing oral intake, and that he had become dehydrated to account for the changes in blood chemistry. No explanation for the hypothermia appears to have been made.
- 16.26 On the 27th September he was returned to the main ward at the hospital and it was noted he was slightly more orientated. Medical records also show that on the 30th September a specific statement was made that he was not to have intravenous fluids.
- 16.27 On the 2nd October 2008, it was noted that a Police Officer investigating the attack on Mr North was considering interviewing him. However, the Clinical Nurse Practitioner on duty at the time stated that he was not fit for interview. The following day he was transferred back to HMP Whitemoor.
- 16.28 At the time of his first medico-legal report Professor 1 had not reviewed Mr North's medical notes from HMP Whitemoor. He was however aware that on the 18th November 2008, Mr North had been again transferred to Hospital 3 as it had been noted that his temperature was 32 degrees centigrade, his sodium 150 and his heart rate varied between 38 and 45 per minute. As a consequence, he was rehydrated and warmed up.
- 16.29 When Professor 1 first examined Mr North on the 22nd December 2008, he established that he was only able to remember small amounts of his

time in Hospital 2, possibly the last two or three days. He records that at the time of that examination Mr North was fully able to stand up, walk in, shake hands, talk and smile. His temperature at that time was 34.3 degrees centigrade and his blood pressure had recently been recorded as 118/68. His fluid intake was being monitored and had been reasonable, however, he needed constant encouragement.

16.30 Professor 1 describes Mr North as a well-built Afro-Caribbean man who looked healthy, and whose weight was appropriate for his height. His speech was clear and on observation there was no obvious neurological loss. He was socially appropriate throughout the examination, smiling appropriately, sitting in a relaxed fashion, and at no point did he become irritated or in any way upset.

16.31 Mr North was clearly able to understand questions and commands and always responded accurately and quickly to any requests. He could smile quickly and could use his limbs as part of his communication. There was no suggestion of any impairment in the use of language. At no point was it suggested that he could not understand language or follow commands.

16.32 That said, Professor 1 notes that Mr North was essentially unwilling to communicate much. He did indicate that he could see no point in Professor 1's presence or examination. He stated that he had no concerns, and that he was not concerned about the original incident although he had no obvious memory of it.

16.33 Professor 1 states that given Mr North's unwillingness to communicate and to respond to direct questions, it was difficult to establish his cognitive state in any formal way. However, the following observations gave some indication. Firstly, he was clearly aware of his surroundings, he behaved appropriately at all times, and he did not express any delusional or incorrect ideas. Secondly, it was apparent from the "*senior nursing prison officer*" that he knew his way around the hospital wing, and that he learned his way reasonably quickly. It was also apparent that he knew who the various Officers were. He had not behaved at any time in a way to suggest confusion or disorientation. Thirdly, he was able to tell Professor 1 that he was at Prison 1 and how long he had been there.

16.34 Professor 1 notes that at the time of this examination, the only medication that Mr North was taking were vitamin supplements.

16.35 Within his medical report Professor 1 uses the established World Health Organisation's (WHO) model of illness in order to provide a descriptive summary of Mr North's medical condition at the time of his examination. He notes that his main diagnoses identified past and present were:

- *“Head Injury (06.09.08)*
 - *right temporal skull fracture*
 - *right frontal intracerebral haemorrhage*

- *Dehydration*
 - *hypernatraemia, raised urea, raised urine and blood osmolality*

- *Hypothermia (32 degrees C to 34 degrees C)”*

16.36 Professor 1 further notes that the main symptoms and signs were:

- *“Post traumatic amnesia of three weeks*
- *Hypothermia*
- *Not drinking much”*

- 16.37 Within his report Professor 1 then provides a detailed narrative recording his opinion and interpretation of Mr North's medical condition at that time. Following on from that he then records his professional prognosis and the requirements for the future management of Mr North.
- 16.38 Professor 1 states that there is no doubt that Mr North sustained a head injury. The obvious evidence includes the skull fracture seen on the CT brain scan, and the bleeding into the brain (right frontal lobe and right basal ganglia). There was also some minor subarachnoid bleeding and some evidence of minor hydrocephalus in the acute phase.
- 16.39 He states that the severity of the head injury was difficult to evaluate for two reasons. First, Mr North was not willing or able to communicate appropriately at that time, thus not allowing a very accurate assessment of his clinical situation. Second, he had an undoubted additional illness which in itself would also alter his clinical state. Specifically, it would affect his memory which is the major measure of the severity of a head injury.

- 16.40 Professor 1 goes on to state that nonetheless it was possible to make a reasonable estimate of severity. There is much contemporaneous evidence to suggest that Mr North was confused probably until the end of September, i.e. for about three weeks. This is entirely consistent with his own spontaneously generated statement that he could only remember the last few days in Hospital 2. Therefore, there seems little doubt that his post-traumatic amnesia extended for a maximum of three weeks.
- 16.41 However, it must be noted that for some of that time he was experiencing problems with reduced body temperature and altered body biochemistry, and that he was given major tranquillizers. These events may have affected his ability to lay down memories. Consequently, it is possible that his period of post-traumatic amnesia was, in fact, limited to about one or two weeks.
- 16.42 Professor 1 states that a person who sustains a head injury with a period of post-traumatic amnesia extending between seven and twenty one days (the limits of certainty), has certainly sustained a significant head injury. However, it is possible to recover either completely or more or less completely from such a head injury. The assessment in 2008 would suggest that Mr North had recovered well from the specific neurological damage. Although a detailed assessment of his cognitive function was not possible, it is worth noting that there were no focal motor losses evident. He behaved in a way to suggest that he was fully orientated and aware of his surroundings. His lack of co-operation in itself

demonstrated an ability to think and to make choices. Professor 1 at that time concluded that Mr North had suffered a head injury of some significance, but that the neurological losses were now small if present at all.

16.43 Professor 1 goes on to state that it is evident that in addition to the direct brain damage from the skull fracture and assault, and the intercerebral haemorrhage, Mr North had also experienced additional medical problems. He evidently had a tendency to have a low body temperature, sometimes sufficiently low to constitute a significant threat to his life. Body temperatures of 32 degrees centigrade were severely low.

16.44 It was also notable that he became dehydrated, and this accounted for the raised sodium and other biochemical abnormalities including the increased blood and urine osmolality. The dehydration almost certainly was secondary to inadequate fluid intake. There was no suggestion that he was losing excessive amounts of fluid through his urine. The precise cause of this problem was considered difficult to determine.

- 16.45 Professor 1 suggests that one possibility was that he had sustained damage to his hypothalamus. This is the part of the brain that controls vegetative functions such as blood pressure, respiration, temperature, appetite and drinking. Damage to this area could explain Mr North's difficulty in controlling his body temperature, and also his lack of drinking (due to absence of thirst). A lack of drinking itself would account for most of the biochemical changes seen.
- 16.46 The alternative explanation is that Mr North had sustained damage to his pituitary gland, which is located just underneath the hypothalamus. Damage to the pituitary gland could then cause various endocrine abnormalities such as a reduced secretion of thyroid hormone and altered production of various other hormones. These could account for his low body temperature, although they are less likely to account for his lack of drinking.
- 16.47 Professor 1 states that both conditions are rare. Damage to the pituitary gland has been reported in about one or two per cent of people with head injury. He suggests that some reports indicate a much higher frequency, but these are less reliable. Other research supports the lower figure. He also reports that damage to the hypothalamus in someone who has few if any other problems are unreported to his knowledge. It is certainly something that he has never seen personally.
- 16.48 At the time of that examination Professor 1 concluded that the most likely cause is damage to the control over the pituitary gland with various

endocrine abnormalities, possibly with secondary loss of thirst causing additional problems. He considered that there is a high medical priority in trying to establish the cause, plus a high priority on establishing a treatment that would help Mr North maintain adequate hydration and an appropriate body temperature.

16.49 Professor 1 also considered Mr North's mental capacity, starting from the premise that someone has mental capacity unless proven otherwise. He notes that Mr North had the capacity to understand communication with no significant impairment of language; however, it was difficult to determine to what extent he understood complex ideas. He concludes that there was no evidence that he could not understand at a level similar to that prior to the attack.

16.50 The individual also needs to be able to retain information sufficiently long enough to come to some judgement. Although Mr North had previously been amnesic there was no evidence that this was the case at that time. Professor 1 concludes that the available evidence would suggest that he had memory that was sufficient to hold in his mind most of the major facts needed.

16.51 The final requirement in determining mental capacity is that Mr North should be able to make a reasoned judgement. At the time there was no suggestion that he had a disorder of reasoning. He was not deluded. Indeed, Professor 1 notes that he appeared well enough to be able to reason that he did not wish to participate in the assessment of his current

state, and therefore to act in a way that made assessment difficult without him being aggressive or otherwise confrontational.

16.52 Based upon the factors outlined above, in his professional opinion, Professor 1 concludes that at the time of this examination Mr North did have the capacity to participate in a legal process. He does, however, make a number of additional observations.

16.53 Firstly, when Mr North's body temperature dropped or his metabolic state changed sufficiently, he may well lose this capacity. In other words, his undiagnosed other illness may in itself alter his capacity from time to time.

16.54 Secondly, Mr North would have no memory of the incident on the 6th September 2008 and would not be able to give any information about the incident itself, its immediate aftermath and to an extent, its immediate precedents. Professor 1 notes that it is always difficult to establish reliably the degree of retrograde amnesia (i.e. forgetting before an index event). In general, however, someone with a period of post-traumatic amnesia extending between seven and twenty one days would probably be amnesic for between fifteen minutes and several hours before the index event. Thus it is possible that Mr North may remember accurately and for himself events up to about fifteen minutes before the incident that caused the head injury. However, it is unlikely that he would remember events in the preceding minute or two, and not at all that likely

that he would remember events over the preceding ten or fifteen minutes.

16.55 Professor 1 observes that during this examination Mr North's behaviour was not aggressive at all, which was a marked contrast to situations recorded in other medical notes. He indicates that this may arise from damage to the frontal lobe which can lead to alterations in social interaction. Sometimes, it leads people to be more aggressive and less socially appropriate. However, it can also lead to apathy. Another possible explanation is that this was secondary to the general change in Mr North's biochemical state. If he had become hypothyroid, or had other changes in pituitary gland function, then he may well have secondarily altered his personality.

16.56 In the final part of this report, Professor 1 provides some narrative around his professional prognosis of Mr North's condition and the requirements for his future management.

16.57 As far as the head injury is concerned, Professor 1 observes that at the time of this examination it was only some four months since the original assault, on 6th September 2008, and in as far as there were any residual difficulties from the brain damage itself, these are likely to recover further. He does stress however that Mr North's period of post-traumatic amnesia will not reduce and that he will never regain those memories that he has currently lost surrounding the acute event. Over time he may learn what happened and thus appear to remember events, but these

will not be genuine personal memories. He is at risk of developing epilepsy, but this risk is low.

16.58 His functional prognosis is determined primarily by the other problem, namely, his inability to control his body temperature, and his tendency to become dehydrated and to develop biochemical abnormalities. At the time Professor 1 was unable to give a prognosis for this condition as the underlying cause was not known. He does, however, say that if Mr North was found to have pituitary insufficiency or other problems with this pituitary gland, then it should, in principle, be possible to ameliorate this completely using replacement therapy.

16.59 Professor 1 concludes that Mr North's future management needs to focus upon the diagnosis and then treatment of his hypothermia and dehydration, recommending that specialist medical support be utilised in order to progress this requirement. He also indicates that in the meantime Mr North should be kept under close supervision in order to actively monitor his body temperature and level of hydration. He adds that if it is subsequently discovered that Mr North has pituitary gland dysfunction, and if this is treated successfully, then it may have the effect of reversing his apparent personality change. He may return to being as aggressive as he once was. In relation to the head injury, at that time there were no specific needs around rehabilitation, primarily as it was deemed that there were no specific problems remaining.

16.60 Professor 1 carried out a second medical examination of Mr North on the 8th July 2010. Again, this examination was conducted at Prison 1. Following that examination, Professor 1 produced a comprehensive medico-legal report dated 28th July 2010. He makes it clear at the start of his report that the content is based upon his examination of Mr North, copies of notes from HMP Whitemoor, copies of notes from Hospital 3, NHS Trust 3 and PCT 1.

. In this report Professor 1 emphasises the point that it is supplementary to his first report and contains additional and new information both from Mr North himself and the medical notes.

- 16.61 Professor 1 reports that on this occasion Mr North was able to communicate more fully than was the case when he was examined in December 2008. Mr North confirmed to him that he did not think that he had any significant past medical history.
- 16.62 Professor 1 notes that the first relevant entry in the prison medical record is a request for Mr North to be seen at 14.30 hours on September the 6th 2008, when he was found in his cell as the possible victim of assault. He had numerous wounds to his head and arms. When seen in Healthcare he was described as being unstable on his feet, unable to say which day it was, and he could not remember the morning. He had head wounds, and cuts and stabbing injuries to the head. An ambulance was called and he was taken to the Accident and Emergency Department at Hospital 3.
- 16.63 The ambulance record notes that he had some slurred speech, that he was confused, and that he had constricted pupils which were unreactive to light. Mr North was described as being “*unco-operative*”. The Accident and Emergency Department notes record that he was confused. The notes also state that he had a laceration on the right wrist which was sutured.
- 16.64 Professor 1 notes that Mr North returned to the prison Healthcare Centre at around 19.30 hours on the evening of the 6th September following his discharge from Hospital 3. It was recorded that he had vomited on the

return journey to the prison and on his arrival a laceration to his left hand was cleaned.

16.65 Records from HMP Whitemoor show that Mr North was closely observed overnight and his pulse became irregular shortly after midnight. By 03:00 hours it had dropped to 40 beats per minute. Shortly afterwards he was taken back out to hospital, firstly to Hospital 1 and later that day, Sunday the 7th September, to Hospital 2.

16.66 Professor 1 notes that on the 3rd October 2008, Mr North was discharged from Hospital 2 and was returned to the Healthcare Centre at the prison. He was described at that time as requiring prompting to take fluids and food. In addition, he was described as being co-operative but with evidence of ongoing confusion. The prison medical record states that during the course of that night he was disturbed, confused and unsure of his location. He had no recollection of the assault and refused to take any antibiotics as he thought that he was well. He remained under observation and had various blood tests undertaken. A community occupational therapist visited on the 16th October 2008 when he was described as still being disorientated. He was also described as being paranoid.

16.67 By the 5th November 2008, he was still noted to be confused and unsteady on his feet. His sodium level was rising and he was being encouraged to drink more fluids. On the 8th November he was noted to

have a body weight of 67 kilograms. This represented a loss of 3 kilograms from the 15th October.

16.68 Further examination of his medical records from HMP Whitemoor shows that on the 12th November 2008 he was still showing symptoms of being confused. By the 18th November his condition remained the same and he was recorded as having a Glasgow Coma Scale Score 14/15. He did not know which prison he was in or the day or date.

16.69 He had a heart rate of around 38, with first degree heart block. His body temperature was below 34 degrees centigrade. By 15.00 hours that afternoon his temperature had dropped to 32.5 degrees centigrade.

16.70 Later that day, the 18th November 2008, he was transferred from HMP Whitemoor to Hospital 3. On arrival he was noted to have a blood pressure of 91/71 and to be confused. His body temperature was initially unrecordable, but eventually became recordable at 33.3 degrees centigrade. At this time he was re-warmed, given fluids and he had a chest x-ray and CT brain scan, both of which were reportedly normal. He was recorded as "*refusing to drink*".

16.71 On or around the 20th November 2008 an MRI brain scan was undertaken, and this showed a small linear area of encephalomalacia in the right medial temporal region consistent with previous trauma.

16.72 When Mr North's medical condition was reviewed on the 21st November the problems noted included:

- *admission with hypothermia and bradycardia*
- *lower platelet level*
- *low potassium level on admission*
- *low cortisol level (77)*
- *abnormalities on the blood film suggestive of hepatitis*
- *persistent hypothermia*
- *recent onset hallucinations*

16.73 Later that day, Mr North was seen by an endocrinologist who suggested that a short Synacthen test was undertaken, and suggested starting hydrocortisone.

16.74 Records show that on the 24th November 2008 the short Synacthen test was reviewed with a pre-test level of 167 and a post-test level of either 374 or 574. Professor 1 observes that he had difficulty reading the handwritten note! At that time it was recommended that the hydrocortisone be reduced and stopped.

16.75 Professor 1 states that following Mr North's discharge from hospital and return to prison on either the 2nd or 3rd December 2008, he was unable to find any discharge summary for Mr North within his medical notes. It was not clear from the records what conclusions were reached in relation to the various problems identified.

- 16.76 Professor 1 notes that more recently Mr North has been seen at the Department of Endocrinology, Hospital 6, by Consultant 3, Consultant Physician and Endocrinologist. He was first seen on the 26th February 2009. At that time Consultant 3 noted the assault in July 2008 on Mr North, in addition to the one in September. In his letter dated 1st April 2009 Consultant 3 notes that Mr North probably has no change in sexual interest or function and that he was able to maintain an erection. His pulse and blood pressure were described as being satisfactory.
- 16.77 Medical records show that on the 25th March 2009 Mr North underwent a further MRI brain scan. The findings are recorded as *“a thin gliotic is demonstrated in the posteroinferior right frontal lobe, running in the coronal plane between the insula and the anterior margin of the third ventricle. T2W gradient echo sections demonstrate signal intensity reduction around the margins of the cavity, in keeping with the presence of products of haemorrhage. The findings are likely to be the consequence of previous intracranial haemorrhage with residual gliosis.”* It was also noted that the pituitary gland was normal with no evidence of tumour.
- 16.78 Medical records also note that Mr North underwent pituitary function tests which were entirely normal. It was also established that he was able to concentrate his urine normally. It was concluded that he had a lack of the sense of thirst as an isolated phenomenon.

16.79 When concluding his review of Mr North's medical history, Professor 1 states that he was unaware of any other specific medical problems and Mr North himself did not report any.

16.80 Dr Louis Loizou carried out a paper review of Mr North's medical and prisoner records in September 2010. Based upon the content of those records, he produced his first medical report dated the 8th September 2010.

16.81 At the start of his report, Dr Loizou documents the papers that have been made available to him:

1) Folder containing the following:-

1a) Professor 1's reports dated December 2008 and July 2010

1b) Professor 2 – tele-conference note February 2010

2a) Patient records

2b) Pathology results

2c) Care Plans

2d) Communications

3) Lever arch file volume 1 consisting of:-

3a) 2 CDs containing radiological images

3b) NHS Trust 2 copy notes

3c) NHS Trust 3 copy notes

- 3d) NHS Trust 4 copy notes
- 3e) Legal Practice 1 correspondence

- 4) Lever arch file volume 2 consisting of:-
 - 4a) Copy notes from Hospital 2

- 5) Lever arch file volume 3 consisting of:-
 - 5a) Copies of notes as well as copies of relevant correspondence from HM Prison Healthcare system – Whitemoor

- 16.82 Dr Loizou has carefully outlined his brief at that time, which was to act as an independent neurology expert, investigating the medical aspects of the case in support of the lead investigator. Specifically, he was tasked with examining the medical records of Mr North in order to ascertain his state of health prior to the attack on the 6th September 2008, then to consider the clinical events that followed on from that incident and to determine, without examining Mr North, the extent to which he has suffered neurological or any other deficit.
- 16.83 At the start of this medical report Dr Loizou reviews and summarises the content of the two medical reports prepared by Professor 1. Dr Loizou concludes that he agrees with the summary of events as recorded by Professor 1, and concurs with the views that he expresses in both of his medical reports. He also makes it clear that he fully endorses the opinion of Professor 1 that when Mr North is subsequently released into the community, he will require a greater amount of support than he would have done, but for the traumatic brain injury.
- 16.84 Dr Loizou then reviews the notes from HMP Whitemoor Healthcare. There is an entry dated the 22nd July 2008 that reads, "*Seen upstairs in Health Care Centre after general alarm in the gym. Mr North unwilling to talk about what had happened, approximately 3cm laceration to forehead and superficial laceration to left cheek, swelling around both wounds, also evidence of nose bleed, pupils equal and reacting, states he has a headache, no nausea or dizziness. Asked Doctor 1 to look at*

it. Sutured by Doctor 1. Moved to Segregation Unit, for suture removal on Sunday 27th September 2008.”

16.85 Mr North’s prison medical record contains a number of subsequent entries throughout July and August 2008, which refer to segregation and cellular confinement.

16.86 On the 6th September 2008 the entry reads as follows, “15.46 hours. At approximately 14.30 hours asked to attend C Wing where Mr North had been found in his cell as the possible victim of assault. He had numerous wounds to his head and arms. Taken to Healthcare where his wounds could be fully assessed. Bleeding stopped and Senior Officer 7 informed of incident and call placed out to Suff Doc.”

- 16.87 At 15.54 hours that afternoon he was noted to be *“unstable on his feet, unable to give the correct date, could not remember his whereabouts that morning; suspect concussion, head injury, cuts stabbing injuries to head. Ambulance arrived at 15:50 hours, removed to A&E.”*
- 16.88 At 19.52 hours the record states, *“Returned back to Healthcare from A&E following alleged assault on C Wing. Brought back into Healthcare in a wheelchair, assessed in treatment room, has lacerations to head x 3, two are stitched and one is glued, area covered with a bandage. According to information sent with prisoner, these sutures have to be removed in 12 days time. Laceration to right wrist which is sutured, covered with an opsite dressing, sutures to be removed in 10 days time. Laceration to left hand in between fingers, areas clean, using saline to remove some dried blood, gauze and bandage to secure, sutures to be removed in 12 days time. According to information which accompanied prisoner, BP 135/90, pulse 72. Pupils equal and reacting to light. According to Senior Officer who accompanied prisoner he vomited once on return to prison.”*
- 16.89 The entry dated the 7th September 2008 refers to an intracerebral haemorrhage extending into the internal capsule and into the right ventricle and temporal bone fracture. Mr North remained under observation at HMP Whitemoor from 19.52 hours (6.9.2008) through until 03.50 hours (7.9.2008). At 00.30 hours on the morning of Sunday the 7th September 2008 it was noticed that his pulse had become irregular (62 bpm), BP 130/80. SuffDOC were contacted and they

advised regular observations which showed pulse “40 bpm irregular” at 03.00 hours, “40bpm” at 03:30 hours and “39bpm BP 140/90” at 03.50 hours. Whilst there was no evidence of deterioration in mental state, paramedics were called to the prison and after further assessment transferred Mr North to Hospital 1 A&E Department.

16.90 Whilst at Hospital 1 Mr North was given his first CT head scan. He was then transferred to the Hospital 2 Neurosurgical Unit where a further CT scan on the 8th September 2008 was carried out. This confirmed a haemorrhage in the right frontal lobe and other abnormalities. He was observed and monitored for his confusion, fluctuation in level of consciousness and abnormalities in body temperature and fluid/electrolyte balance. No surgical procedure was carried out.

16.91 Further details of his medical treatment and his ongoing condition whilst at both Hospital 1 and Hospital 2 are documented later in this chapter.

16.92 There are daily entries thereafter recording communications between prison and hospital staff. On the 13th September 2008 it was recorded that Mr North’s mobility was better, that he had taken a shower and was using a frame. On the 14th September 2008 a communication from Hospital 2 reported that Mr North had hit one of the Officers with him at the hospital and because of that incident he was now double-cuffed. He was subsequently started on olanzapine for his aggressive behaviour.

- 16.93 On the 16th September 2008 the hospital reported to the prison Healthcare that Mr North had poor dietary intake and continued to be agitated and disorientated. On the 18th September he was reported to be lethargic and refusing to have any food, whilst on the 19th September he was thought to have post-traumatic amnesia.
- 16.94 On the 21st September it was recorded that he was very reluctant to eat and drink and the following day, 22nd September, he was observed to be dragging one leg. There was further deterioration in his condition on the 24th September. On that date he was suffering from low blood pressure, low temperature and possible dehydration. Intravenous infusion was commenced in order to rehydrate him.
- 16.95 By the 30th September 2008 the hospital reported that there had been very little change in Mr North's condition, however, by the 2nd October it was recorded that he did get out of bed, shower and breakfast "*without problem*".

- 16.96 On the 3rd October 2008 Mr North was described as “*mobilising well*” and he was subsequently transferred back to HMP Whitemoor Healthcare, utilising prison transport. All medications except antibiotics were discontinued prior to transfer. The following day it was recorded that he was confused and agitated at times and he refused to take antibiotics but took fluids and ate biscuits.
- 16.97 On the 5th October 2008 Mr North enquired with Healthcare staff if any other prisoners currently located within the unit were Muslims. On the 16th October he was assessed by the occupational therapist who concluded that he was orientated to place, month and year, but not to day or date. It was reported at that time that “*he does have paranoia*”. On the 8th November Mr North spent time in the exercise yard.
- 16.98 On the 18th November Mr North was seen in the prison Healthcare by a locum GP because of remaining confused and becoming more confused than was normal for him. On examination his Glasgow Coma Score was observed to be 14/15. His body temperature at that time was deemed to be unrecordable, i.e. below 34 degrees celsius. As a result of these findings Mr North’s case was discussed with the Neuro-surgical Registrar at Hospital 2. The conclusion at that time was for him to remain in prison. However, later on that day Mr North appeared more confused and unsteady on getting up. As a result, Mr North was transferred to the A&E Department at Hospital 3. He was subsequently admitted and underwent further investigations including an MRI/CT brain scan. It was noted that Mr North had a low body temperature.

- 16.99 Mr North remained in the care of Hospital 3 until his discharge back to HMP Whitemoor on the 2nd December 2008, where he remained under close supervision within Healthcare. On the 17th December he was considered fit to travel and he was transferred to Prison 1.
- 16.100 Mr North's prison medical records show that on the 19th December 2008 prison Healthcare staff established communication with Consultant 2, Consultant Neurosurgeon at Hospital 2, who arranged for Mr North to be transferred to the care of Consultant 4, Consultant Neurosurgeon at Hospital 6. On the 21st December 2008 it was noted that Mr North remained reluctant to come out of the cell and interact with peers.
- 16.101 Thereafter, Mr North was monitored carefully for any evidence of deterioration in his general or neurological condition. His reluctance to interact with peers was noted again on the 22nd January 2009 and he required constant prompting to increase food intake, as recorded on the 31st January 2009.
- 16.102 On the 13th February 2009 it was noted there were no problems and that Mr North remained cheerful and pleasant. He did, however, require prompting to eat and drink. On the 21st February 2009 he had an episode of dizziness, nausea and vomiting.

16.103 Prison medical records indicate that by the end of March 2009 Mr North was taking fluids well and he was more interactive, asking to go to the gym. By the end of April he was requesting food and becoming more cheerful and chatty. On the 9th June 2009 discussions took place as to whether Mr North could go back to normal location and to participate in gym activities. Whilst no information is specifically recorded, by virtue of the fact that some months later Mr North remained resident in the prison Healthcare, a decision must have been taken not to progress that option at that time.

16.104 Dr Loizou notes that the next relevant entry in the prison medical records is on the 14th October 2009, when it is recorded that Mr North had a high serum sodium level. Furthermore, on the 21st December 2009 there is reference to a conversation between prison Healthcare staff and Consultant 5, Consultant Haematologist at Hospital 5 relating to Mr North developing thrombocytopenia.

16.105 Finally, in relation to Mr North's prison medical records, Dr Loizou notes that there is a copy of a letter dated "(Clinic) 26th February 2009, (typed) 1st April 2009" from Consultant 3 to the prison doctor, Doctor 2. Consultant 3's letter refers to his first encounter with Mr North. It was noted that he was taking thiamine 200 mg daily and vitamin B compound, one tablet daily. Various blood tests and an MRI brain scan were arranged. A further letter typed on the 19th June 2009 refers to the various blood tests as being normal and the MRI scan showed evidence

of previous intracranial haemorrhage with residual gliosis in the right frontal lobe and anterior margin of the third ventricle.

16.106 Dr Loizou then goes on to review the papers contained within the aforementioned lever arch file, volume 1. This included notes from NHS Trust 2, Hospital 6, NHS Trust 4 and correspondence with Legal Practice 1.

16.107 These papers included an A&E card dated the 18th November 2008 referring to Mr North's admission to Hospital 3, from HMP Whitemoor, at 17.10 hours. The reason for admission on this occasion was bradycardia 23-56 beats per minute and increasing confusion with hypothermia less than 31 degrees celsius. His BP was recorded as 91/71 and his Glasgow Coma score 15/15 (as recorded in the ambulance card), but at times 14/15 as recorded in the A&E observation chart.

16.108 During this period as an inpatient, records show that Mr North had a low platelet count and low potassium count, low cortisone levels and persisting hypothermia. A Synacthen test was carried out, however, no specific treatment was given, other than rehydration and keeping him warm, prior to his transfer back to HMP Whitemoor on the 2nd December 2008.

16.109 Dr Loizou notes that there is an MRI brain scan report dated the 20th November 2008 which states the following, "*small cavum septum*

pellucidum incidentally noted. Otherwise ventricles unremarkable. In the right medial temporal region there is a small area of linear encephalomalacia with low signal around, particularly marked on gradient echo imaging consistent with haemosiderin blood products resulting from an old haemorrhagic contusion here. This is presumably the result of the old injury. The cortex generally is well maintained. No other significant lesion.”

16.110 Dr Loizou also refers to a CT head scan report dated the 18th November 2008, which reads as follows, “*Subtle change in density in the region of the right sylvian fissure of uncertain clinical significance. No other abnormality seen. If further imaging required suggest MRI.*”

16.111 With regard to the records from Hospital 6, Dr Loizou refers to a copy MRI scan report dated the 25th March 2009, which reads, “*A thin gliotic cavity is demonstrated in postero-inferior right frontal lobe running in the coronal plane, between the insula and anterior margin of the third ventricle. T2W gradient echo sections demonstrate signal intensity reduction around the margins of the cavity in keeping with the presence of products of haemorrhage. The findings are likely to be a consequence of previous intracranial haemorrhage with a residual gliosis. Correlation with any previous imaging would be desirable for confirmation. No other intracranial lesion is detected. The pituitary gland displays normal signal characteristics and an enhancement. There is no evidence of pituitary neoplasm.”*

16.112 In this report Dr Loizou goes on to review the papers contained within the aforementioned lever arch file, volume 2. As previously mentioned this includes notes from Hospital 1 and Hospital 2. He makes reference to the fact that there are copies of reports of CT scans dated 7th, 8th, 11th and 13th September 2008. He states that they demonstrated the presence of haematoma in the right frontal lobe abutting and slightly effacing the frontal horn of the right lateral ventricle and a depressed fracture of the right temporal bone with a small amount of associated underlying subarachnoid blood [CT scans dated 7.8.08 – 8.9.08]. There was no evidence of an aneurysm in the right middle cerebral artery; the rest of the intracranial vasculature was unremarkable (CT Angiogram 8.9.2008). The second and third scans did not show any change from the first. The fourth CT scan on 13th September 2008 demonstrated that the right basal ganglia haematoma was now slightly lower density. The ventricles were not dilated.

16.113 These medical notes record that Mr North was brought by ambulance to Hospital 1 A&E Department at 06.28 hours on the 7th September 2008 and examined at 06.45 hours.

16.114 It would appear that the severity of the head injury following the assault and the deterioration in his condition was not appreciated initially. That said, it was considered necessary to carry out a CT head scan, as a result of which Mr North was transferred to the Hospital 2 Neurosurgical Unit. It was noted that the Glasgow Coma score was reduced at 14/15 or at times 13/15 in both hospitals, but he remained stable and no

neurosurgical intervention was undertaken regarding the intracerebral haematoma. No focal neurological abnormalities were noted at any stage, but on the 25th September 2008 his general health deteriorated and he was admitted to the Intensive Care Unit for two days. He was transferred back to the ward on the 27th September. The main abnormalities were raised serum, sodium, urea, creatinine and urine osmolality. During this period of stay, it was noted that Mr North was not eating and drinking properly and there were periods of low body temperature.

16.115 Dr Loizou notes that the medical records contain no actual discharge summary.

16.116 In relation to the papers in the lever arch file, Volume 3, Dr Loizou summarises a number of documents that form part of Mr North's medical record. These entries are best described as historical and generally refer to numerous, fairly low level injuries and ailments. The notes contain nothing that adds value to the issues relevant to this investigation.

16.117 In this report Dr Loizou makes reference to the fact that he was able to view the CT head scans dated the 7th, 8th and 13th September 2008. They showed a right temporal bone fracture. The two CT head scans dated 7th and 8th September 2008 showed a haematoma in the deep part of the right frontal lobe extending in the hypothalamus, and abutting the right side of the third ventricle. On that side the haematoma extended

into the right temporal pole. There was a small amount of blood in the right lateral ventricle. There was also a smaller haemorrhage in the left deep frontal lobe abutting the left side of the third ventricle and present in the hypothalamus.

16.118 The CT head scan dated the 13th September 2008 showed partial resolution of the haemorrhage and of the surrounding oedema in the upper part of the right frontal lobe. There was also partial resolution of the compression of the right frontal lobe.

16.119 Having reviewed the CT head scans, Dr Loizou attributes Mr North's neurological condition, as described in the medical records and in the medical reports by Professor 1 and Professor 2, to the structural damage suffered by the brain as a result of the alleged injury to Mr North's head on or about the 6th September 2008.

16.120 Dr Loizou concludes his first report by documenting his professional opinion regarding Mr North's medical condition and concurrence with the views expressed by Professor 1. He states that there is clear evidence that Mr North suffered traumatic brain injury with contusional haemorrhage affecting the right frontal lobe and the third ventricular structures of the hypothalamus. As a result of that brain damage, Mr North has been left with a number of physical deficits, namely inability to control his body temperature and to regulate the amount of the fluid he was taking in through lack of ability to experience thirst. In addition, Mr North had lost his sense of smell and taste.

- 16.121 Mr North had also suffered cognitive impairment to the extent that Professor 1 did not consider him capable of mounting a legal challenge on his own behalf. Furthermore, there had been changes in personality to the extent that he was now more docile than he had been in the past.
- 16.122 Although Mr North had not suffered any epileptic seizures so far, the risk of post-traumatic epilepsy remained high at about five per cent or six per cent currently, and would reduce to twice that for the uninjured population ten years post injury and would remain at that elevated level for the rest of his life.
- 16.123 Based upon the information available to Dr Loizou at that time, he did not believe that life expectancy had been affected.
- 16.124 Dr Loizou interviewed Mr North and carried out an examination of him in the medical room at Prison 1 on Friday the 25th March 2011. This consultation and examination were carried out in private. Based upon that examination, documentation available for his reference and the subsequent examination of a Prison Service Cat A vehicle at Prison 1, Dr Loizou produced his second medical report, dated 9th July 2011. The key issues and findings from that report are outlined below.
- 16.125 Dr Loizou's instructions from the lead investigator, prior to his examination of Mr North, were to provide a condition and prognosis report based upon all of the available evidence. To assist with that task,

Dr Loizou was provided with copies of interview transcripts with four Officers from HMP Whitemoor. These raised the possibility of a second self-inflicted head injury by Mr North in a Cat A prison vehicle whilst being transported from Hospital 3 back to prison on the evening of Saturday 6th September 2008. Dr Loizou's instructions were therefore extended to include his opinion as to the relative contribution of the two head injuries sustained by Mr North, i.e. the assault head injury and the self-inflicted head injury, to the structural brain damage and the resultant neurological complaints and deficits.

16.126 At the start of the consultation Dr Loizou spoke with Mr North in broad terms about his social history and general health. Mr North stated that he used to smoke ten roll your own cigarettes per day but had stopped some weeks prior to the consultation. He stated that his current hobbies included going to the gym and playing computer games.

16.127 Mr North stated that during his younger years he worked as a steward at Arsenal Football Club and Lord's Cricket Ground. Whilst at school he took some GCSE exams but left at the age of 15. Thereafter he worked in a number of jobs including electronics.

16.128 At the time of the interview with Mr North in March 2011, Dr Loizou recorded that Mr North's current general health had actually improved but he still lacked the sense of thirst, he still experienced episodes when his body temperature dropped, he was not aware of it and he became hypothermic. As a result he was keeping himself warm with clothes and

blankets and controlling the temperature in the environment in which he was living.

16.129 With respect to treatment, Mr North was taking Paramax which is a combination of paracetamol and Maxolon. These were being taken for migraine-type headaches which started some six or nine months prior to this examination. Mr North described these headaches as like a heartbeat occurring almost every day and he stated that Paramax usually helped. Mr North also stated that he used to take amitriptyline for the headaches and he used to go to bed and sleep them off, but now it was necessary to take Paramax. He thought they were like a migraine headache even though there is no family history of migraine to link it to.

16.130 At that time Mr North stated that since the head injury on the 6th September 2008, he had had the following symptoms:

Headaches – These had affected Mr North on and off since the head injury and he used to treat them with amitriptyline as stated above. In the 7 months or so prior to the examination in March 2011 the headaches had become more frequent and have required treatment with paramax, (again as described above). He believed that they were of a migraine type.

Low Body Temperature – Mr North stated that since the incident his body could not maintain the normal body temperature and he could easily become hypothermic and as a result he had to keep himself warm by wearing warm clothes, using blankets and controlling the environment temperature. It has been noted that in the last year or so there have been fewer hypothermic episodes than in the first two years following the head injury.

Tendency to have high serum sodium – Mr North stated that this abnormality was discovered by carrying out routine blood tests whilst in hospital following the deterioration of his health and conscious level after the head injury in September 2008. Dr Loizou concludes that this biochemical abnormality was a consequence of Mr North being unable to feel thirst and drink appropriate amounts of fluid; as a result his serum became concentrated hence the high serum sodium.

Inability to feel thirsty – Mr North stated that since the head injury he had lost the ability to feel thirsty and to take fluids during the day. He did however feel hunger and he was eating appropriately. As a result, Mr North was taught to keep an accurate fluid balance chart every day. He was drinking two litres of fluid per day and keeping a watchful eye on the amount of urine that he passed and its colour. Mr North knew that his urine should be light in colour and if it became too dark he knew that it is concentrated due to not taking sufficient fluid and he corrected it accordingly.

Impairment of short-term memory – Mr North said that since the head injury he had had impaired short-term memory. For instance, he forgot where he had put his pen down or what he had been told to do. Mr North did state that his short-term memory was actually slowly getting better. Mr North informed Dr Loizou that following the head injury he realised that he could not remember any of the period of inpatient treatment at Hospital 2, Hospital 1 or Hospital 3. In addition, he had no recollection of the circumstances surrounding the assault in which he acquired the brain injury. He did however appear to have reasonably good long-term memory.

Impairment of concentration – Mr North stated that he used to read a lot of books, but since the head injury he could not concentrate long enough to read. He put the book down and the next day he could not follow the story that he had been reading. As a result, he derived no

pleasure from reading anymore. Mr North said that recently he discovered that he derived pleasure when he read animal books in which there were pictures accompanying the text.

Impairment of sense of taste and smell – since the incident Mr North had noticed impairment of his ability to smell and taste his food, but he thought that his sense of taste was actually gradually coming back. Mr North said that he used to enjoy eating but now he tended to pick the food that he ate and as a result he had lost some weight.

Alternation of sleep pattern – Mr North informed Dr Loizou that since the head injury he didn't sleep much at all. He tended to sit up all night. He might get between 3-4 hours sleep from about 3 in the morning until about 7 o'clock when he got up.

16.131 Upon direct questioning, Mr North said that he had normal vision and hearing and normal sensation in his arms and legs. He could control his bladder and bowel sphincters normally. He did state that he used to have poor balance and he had a number of falls immediately after the head injury whilst he was resident at HMP Whitemoor. However, his balance had been good and he had not experienced any falls in the last year or two since the assault. He had not suffered any blackouts or epileptic fits since the head injury.

16.132 During the course of the consultation, Dr Loizou asked Mr North to recount to him the circumstances relating to the assault. Mr North informed him that he remembered being in the Segregation Unit at HMP Whitemoor and at the end of that period he recalled going to his cell in A wing to collect his property which included clothes and a stereo. Mr North recalled picking up his bag and putting it on a trolley which he was then to push to a cell in C wing. He remembered walking along the hallway between the cell in A wing to the new cell in C wing and walking past the office. He could not recall seeing any Prison Officers or prisoners whilst he was walking along the hallway. He did remember that this activity took place during Association time. He did not remember anything about his cell on C wing, but he did remember asking a Prison Officer if he could have a television.

16.133 He further informed Dr Loizou that his next memory was waking up in Hospital 2 with Officers sitting on him attempting to put wrist restraints on him, even though he was already handcuffed. He was told by a nurse

that he had been hallucinating and had assaulted one of the Officers although he had no memory of this.

16.134 When asked more specifically about the assault Mr North said that he remembered being hit with a weights bar by a prisoner and that the assault was unprovoked. Mr North said that he was hit on the forehead and that he was bleeding but that he did not lose consciousness. He said the laceration required five stitches. Mr North remembered being put back into Segregation following this assault. When Dr Loizou returned to the circumstances of the assault again, Mr North stated that he assumed that he had been knocked out as a result of the head injury sustained.

16.135 It should be noted at this point, that in the opinion of the lead investigator, Mr North was becoming confused about the detail of the two separate assaults on him. The initial details, as described in the previous paragraph, clearly relate to the assault in the gymnasium on the 22nd July 2008 and not the second more serious assault in his cell on the 6th September 2008. It was the July attack when he was struck on the forehead with a weights bar and then segregated under Prison Rules for his own protection.

16.136 During the physical examination of Mr North, Dr Loizou describes him as looking well, suitably dressed, well behaved and very presentable. He was fully co-operative and pleasant. He conversed without difficulty; he was sociable and showed the appropriate degree of respect. Mr North

gave a good account of his medical and social history and kept to the point. With respect to higher mental functions, Mr North was fully orientated and showed no evidence of receptive or expressive dysphasia.

16.137 Mr North was able to perform serial seven calculations without difficulty but he was unable to spell correctly the word "world" forward or backwards. Mr North was able to recall two out of three items after three minutes and he carried out the three stage command normally. He was also able to write his name and date of birth, draw a picture of a house and a clock face, write a sentence, read and obey the command to close his eyes. He also copied intersecting hexagons.

16.138 Examination of the cranial nerves showed that he was able to taste a cherry sweet but he was unable to smell a number of odours presented to him. The visual acuity was 6/6 in the right eye and 6/18 on the left side but the visual fields were full and the rest of the cranial nerves were normal.

16.139 Dr Loizou found Mr North had no sensory, motor or cerebellar abnormality at all in his arms and legs. He describes the reflexes as being somewhat depressed but equal throughout and the plantar responses were flexor. The stance and gait were normal. There were no obvious external abnormalities and examination of the cardiovascular system was normal.

16.140 In order for Dr Loizou to assess his findings and reach appropriate conclusions with regards to Mr North medical condition and his future prognosis, he has considered additional documentary evidence to assist him with this task. He has referred to this material in some detail within his second report.

16.141 On the 25th March 2011, prior to his examination of Mr North, the lead investigator provided Dr Loizou with four verbatim transcripts of witness interviews of Officers from HMP Whitemoor, namely Senior Officer 5, Officer 4, Officer 14 and Officer 11. These four Officers escorted Mr North from Hospital 3 back to HMP Whitemoor, using a Cat A transport van on the evening of the 6th September 2008. Those accounts provide evidence that Mr North had repeatedly banged his head on the solid metal and plastic walls of the internal cell. There is also evidence that he vomited once at some point during the journey.

16.142 In his report Dr Loizou confirms that the purpose of the consultation and examination of Mr North on the 25th March 2011 was to ascertain his current state of health and neurological position and also to formulate a

prognosis. He also refers to his inspection of the internal construction of a Cat A van on the 16th June 2011. The purpose of this inspection was to ascertain whether there was credibility in the suggestions made by the relevant prison officers accompanying Mr North from Hospital 3 on the 6th September 2008 that he had sustained significant head injuries during the journey back to HMP Whitemoor.

16.143 There was a form completed by Officer 10 on the 6th September 2008 reporting an injury to a prisoner. The incident time is stated to be between 14.20 hours and 14.30 hours and relates to C wing cell G1-33. The nature of the injury to Mr North consisted of cuts to the front and rear of his head, right ear, right arm and wrist. Officer 10 states that this prisoner first said he had fallen over, however, he doubted that account of events. It is also recorded on this document that Mr North later stated to Officer 6 he had been attacked by five prisoners of the Muslim faith.

16.144 On that same document a member of Healthcare staff, Officer 16, has recorded that at approximately 14.30 hours there was a request to attend C wing. Mr North had been found in his cell having been assaulted. Upon arrival of Healthcare staff he was in an area called the Centre 1s. At this time his injuries are described as being extensive, he was disorientated and unsteady on his feet. He was therefore taken to Healthcare for further assessment.

16.145 A further entry in the Healthcare records by Officer 16, timed 15.45 hours on the 6th September repeats much of the above information, but also states that the bleeding was stopped. Senior Officer 7 was informed of the incident and a call placed for the on call doctor.

16.146 A few minutes later at 15.54 hours, Senior Officer 7 recorded within the medical records that Mr North was unsteady on his feet, unable to give the correct day, could not remember his whereabouts that morning and had suspected concussion. The record also refers to head injuries, cuts and stabbing injuries to the head.

16.147 The East of England Ambulance Service card records that they arrived at the scene at 15.40 hours on the 6th September 2008 and they left at 16.20 hours, arriving at Hospital 3 at 17.10 hours. The crew noted a right and left head laceration and bilateral wrist lacerations. The head injuries were described as slash and puncture wound around the ears and back of head, varying in size and depth. These had been dressed by HMP medical staff at the scene. The ambulance crew also recorded lacerations to both wrists' anterior aspect, defence wounds to hands and in between fingers. "*Possibly assaulted by inmates.*" It was noted that the patient denied this MOI (method of injury) and stated that it was as a result of falling from a bench.

16.148 All observations were recorded as "*non remarkable – neuro-examination inconclusive*". It was recorded that Mr North had some slurred speech, was confused and had constricted pupils that were unreactive to light. They noted the Glasgow Coma score to be 15/15 on two consecutive occasions. For clarity, Dr Loizou has suggested that this measurement cannot be correct because Mr North was clearly confused. Therefore, the Glasgow Coma score was at best 14/15, more likely 13/15.

16.149 The A&E card from Hospital 3 records the time of arrival on the 6th September at 17.17 hours. It makes reference to the observation of multiple head, hand and wrist injuries. The Glasgow Coma score is recorded as “*E3, M6, V3-4, total 12-13/15.*” Multiple head lacerations to front and back of his head were glued and multiple head swellings were noted. There was a 15 cm laceration on the wrist. There were lacerations in the left inter-digital web space and four stitches were used. Mr North was returned back to HMP Whitemoor where he remained under supervision in the Healthcare Centre until the early hours of Sunday the 7th September when he was re-admitted to hospital.

16.150 On this occasion the East of England Ambulance Service records that they were mobile at 04.13 hours on Sunday the 7th September and on arrival at approximately 04:49 hours they found Mr North to have a Glasgow Coma score of 12-13/15 and witnessed rounds of bradycardia. They were mobile to Hospital 1 by 05.24 hours.

16.151 The A&E card from NHS Trust 1 records that Mr North arrived at 06.28 hours on the 7th September 2008, his pulse was 50 per minute and the Glasgow Coma score was 14/15, but with fluctuating level of consciousness. Both pupils were equal and reactive to light. BP was 170/76. The case was then discussed with neurosurgeons at Hospital 2. A CT head scan was carried out which showed an intracerebral bleeding extending into the internal capsule and into the right ventricle. There was a right temporal bone fracture and a small subarachnoid haemorrhage.

16.152 A repeat CT scan and angiogram in Hospital 2 on the 8th September 2008 confirmed the presence of a haematoma in the right frontal lobe, abutting slightly and effacing the frontal horn of the right lateral ventricle. A depressed fracture of the right temporal bone with a small amount of associated underlying subarachnoid blood was shown. There was no evidence of an aneurysm. The scan was repeated on the 10th September and the 13th September 2008 with little significant change, but the haematoma involving the right basal ganglia was now slightly lower density and the ventricles were not dilated.

16.153 In this second report Dr Loizou carried out an evaluation of the first CT head scan that was carried out on the 7th September 2008. This scan was performed several hours after the assault in prison and a few hours after the reported self-inflicted head injury in the Cat A van. It therefore depicts the combined structural damaging effect of the two head injuries.

16.154 This CT head scan shows the following abnormalities:

- depressed right temporal bone fracture with a small amount of subarachnoid haemorrhage under the fracture.
- there is a right temporal subgaleal haematoma but not a frontal or occipital one.
- there is some haemorrhage in the right lateral ventricle, third ventricle, aqueduct and fourth ventricle in the medulla. There is haemorrhage in the intra-ventricular septum and possibly in the right fornix.
- there is haematoma in the right hypothalamic area which extends across to the left hypothalamus.
- immediately opposite the fracture there is an intra-cerebral haematoma within the right frontal lobe, the base of which lies just anterior to the right middle cerebral artery and continues higher up into the right basal ganglia within the territory of the medial

perforating arteries and extending to and abutting the anterior horn of right lateral ventricle.

- there is dilation of the temporal and occipital horns and the upper part of the third ventricle and of the anterior horn of right lateral ventricle with some shift of the rostra midline structures to the left.
- there is early brain swelling bilaterally with effacement of the sulci.

16.155 Dr Loizou notes that the subsequent CT angiogram dated the 8th September 2008 shows no aneurysms. The follow-up CT head scans dated the 8th September 2008 and the 13th September 2008 were viewed and previously reported on in his first medical report. The CT scan on the 8th September 2008 shows extension of the haematoma into the left side of the brain in particular in the left hypothalamus and into the right temporal pole. The CT head scan dated the 13th September 2008 shows some resolution of the intra-cerebral haemorrhage and of the brain swelling.

16.156 The CT head scan dated the 18th November 2008 was made soon after readmission to hospital, precipitated by an episode of deterioration and hypothermia. Dr Loizou states that his CT scan shows remarkably little abnormality except for some low density in the right Sylvian fissure area. An MRI scan made on the 20th November 2008 shows resolution of the haemorrhage and in its place there is an area of atrophy in the right

temporal lobe extending into the hypothalamus and crossing the midline into the left hypothalamus.

16.157 Dr Loizou also viewed the last MRI scan, dated 28th March 2009 and made at Hospital 6. He reports that the appearances are almost identical to those on the 20th November 2008. He states that the lesion is now a low density area coursing horizontally from the area of the right temporal fracture through the entire width of the right temporal lobe and hypothalamus, across the third ventricle into left hypothalamus. It also extends upwards and interiorly in a circular fashion into the white matter of the right frontal lobe.

Evaluation of and opinion on the above information

16.158 In his second report Dr Loizou states that it is clear that Mr North suffered an assault with multiple arm/hand wounds and a head injury resulting in a right temporal bone fracture and a traumatic brain injury at about 14.20 hours on Saturday the 6th September 2008. It is more probable than not that Mr North had lost consciousness for a short period of time after the head injury and before he was found in his cell by Officer 10. The presence of intracerebral, intraventricular and subarachnoid blood on the first CT head scan on the 7th September would indicate that consciousness was probably lost for a short period of time. Mr North then became confused and unsteady, with slurring of speech and becoming at times incomprehensible. Immediately after his injuries he was appropriately managed by the Prison Officers and the medical and nursing staff at HMP Whitemoor.

16.159 Dr Loizou states that he has no doubt that the assault in his prison cell caused the right temporal bone fracture (near the skull base), the subgaleal haematoma, the small subarachnoid haemorrhage on the right side of the brain, the hypothalamic haemorrhage at least on the right side of the brain and at least a proportion of the right frontal intracerebral haemorrhage and its extension towards the right ventricle. It is "*possible/probable*" that the other parts of the intracerebral and intraventricular haemorrhage were caused by the second self-inflicted injury.

16.160 By the time of his timely transfer to the Accident & Emergency Department at Hospital 3, Mr North's Glasgow Coma score was 12/15 or at best 13/15. This clinical picture mandated an urgent CT head scan, discussions with the relevant neurosurgical team and immediate transfer to the nearest neurosurgical unit, which in this case would have been at Hospital 2.

16.161 Dr Loizou is quite clear that, had a CT head scan been performed at Hospital 3, it would have shown the true extent of the damage caused by the assault head injury and would have resulted in admission to hospital, thereby preventing a second head injury from happening and any aggravating effects arising as a consequence.

16.162 In addition, Dr Loizou concludes that the initial management in the Accident & Emergency Department at Hospital 3 was "*rather disappointing*". He is of the view that the staff at the hospital misjudged the severity of the head injury which should have been evident by their own observation of the Glasgow Coma score. Consequently, they failed to keep Mr North in hospital for a CT scan and observation and/or transfer to neurosurgery. "*This failure constituted failure to meet the reasonable standards expected of those practitioners and exposed Mr North to additional significant risks of deterioration which actually materialised soon afterwards*". The lead investigator has subsequently put the concerns raised by Dr Loizou to the Chief Executive of NHS Trust 2. In response to the issues raised, the Trust has written back to the lead investigator accepting that the care provided to Mr North at Hospital

3 on Saturday 6th September 2008 was not up to the standard it would normally expect. The Trust has however sought to provide reassurance that since 2008 the management of head injuries within the Emergency Department has been reviewed and changed to ensure that they are assessed and treated within guidelines that mirror the National Institute for Health and Care (NICE) guidance. The Chief Executive has placed on record the Trust's apologies to Mr North for the standard of care that he received.

16.163 As a result of the failure to admit him to hospital, Mr North was returned to Healthcare at HMP Whitemoor in a standard-use Category A transport van. It was during this journey that he is believed to have suffered further, self-inflicted, head injuries by banging his head against the walls of the cell in which he was confined during transport. Dr Loizou states that his confusional state caused by the assault head injury was aggravated by the confinement in a small space leading to further disorientation and the automatic self-harming behaviour. Mr North would have had no knowledge of what he was doing.

16.164 Very soon after return to Whitemoor, and whilst being monitored by the Healthcare staff there, Mr North's condition deteriorated and he was readmitted to hospital. On this occasion he was taken to Hospital 1 where a CT head scan revealed the extent of his cranial and cerebral injuries. Mr North was subsequently transferred to Hospital 2 where he received treatment as an inpatient for a number of weeks prior to returning to HMP Whitemoor. The Healthcare staff detected a

deterioration in Mr North's condition and arranged his admission to Hospital 3 on the 18th November when his metabolic state was treated and corrected.

16.165 Dr Loizou states that the consequences of Mr North's cerebral injuries had been severe and life-threatening but they have since settled and become manageable. In his opinion this outcome is largely due to the excellent observation, timely management and treatment that Mr North received from the Healthcare staff at Whitemoor from the day of his first head injury to the time he was transferred to Prison 1.

16.166 With respect to Mr North's current state of health (March 2011), Dr Loizou states that he formed the impression that his general health was normal and that there had been no recent episodes of hypothermia or abnormalities of fluid and electrolyte balance of clinical significance. There had certainly been no recent episodes of drowsiness or confusional behaviour relating to any episodes of electrolyte imbalance, dehydration or hypothermia. The neurological examination was normal apart from the impairment of the sense of smell which relates to the effects of the head injury damaging the olfactory nerves.

16.167 It was noted that Mr North had not suffered any epileptic fits following the traumatic brain injury in September 2008. Speech and language functions were normal. Higher mental functions, as tested with the mini mental state test, were normal with the exception of very mild impairment of short-term memory.

16.168 Dr Loizou states that, referring to the memory that Mr North has with regards to the events that led to and followed the assault on the 6th September, it is clear that he can remember some events which can be corroborated by others as being true. However, on balance, Dr Loizou considers that Mr North's memory surrounding that period (the assault) is unreliable. In his view, the precise description of events will have to depend on evidence given by reliable witnesses such as the Prison Officers who were present in the vicinity at that time.

- 16.169 If it is accepted that Mr North was, indeed, assaulted as suggested, on the balance of probabilities he may be expected to have lost consciousness for a short period of time, i.e. seconds or minutes. In such circumstances he would be expected to have a degree of retrograde amnesia, a short period of post-traumatic amnesia and potentially a short period during which his behaviour was confused or automatic.
- 16.170 There is evidence that short-term memory has been impaired since the time of the assault and head injury and although improving, on the balance of probabilities it will never achieve full recovery. It may be reliable with respect to the more significant day to day events and activities.
- 16.171 Dr Loizou noted that whilst concentration was said to have been impaired since the head injury, he did not detect any difficulty with Mr North maintaining attention and concentration during the one and a half hour period that he was with him. Nonetheless, Mr North has noticed that his concentration is very poor when he is reading standard books. He can however, maintain his interest and concentration when he is reading animal books with pictures accompanying the text. This suggests that he uses visual memory to augment his verbal memory and explains why he is able to maintain attention when playing computer games.

16.172 Mr North's loss of sense of smell will be permanent, however it was noted that his sense of taste is slowly improving.

16.173 In relation to sleep pattern, this has been profoundly disturbed and it is more likely than not that it will remain so long term. This is because of the specific area of the brain that has been damaged by the traumatic haemorrhage following the assault.

16.174 It is clear that Mr North has developed post-traumatic migraine which he did not experience prior to the assault. It is concluded that this particular symptom is more likely than not to continue to trouble him for the next year or two at the time of Dr Loizou's report. It may then subside only to recur in the future.

16.175 The syndrome of adipsia and hypothermia relates directly to the structural damage in the hypothalamus following the traumatic intracerebral haemorrhage and it is a permanent loss of specific brain function.

16.176 In Dr Loizou's professional opinion, he does not anticipate that Mr North will develop any additional neurological complications in the future arising from the structural brain damage acquired at the time of the assault head injury and the reported self-inflicted head injury.

Causation of current neurological symptoms and deficits

16.177 The presence of brain swelling and of intraventricular, intracerebral and subarachnoid blood (as shown in the first and second CT scans dated 7th September 2008 and 8th September 2008) are the pathological basis of Mr North showing variation in his conscious level, confusion and inco-ordination/ataxia. The brain swelling and intraventricular blood resolved over a short period of time; following on, the clinical features resolved by the end of 2008 beginning of 2009 and have not recurred as such.

16.178 The presence of a haematoma in the region of the hypothalamus is the pathological basis of Mr North's adipsia, hypernatraemia and hypothermia syndrome, which caused acute deterioration of his general metabolic condition whilst he was in Hospital 2 from the 7th September 2008 to the 3rd October 2008. It was also responsible for his deterioration and admission to Hospital 3 on the 18th November 2008. It is responsible for the continuing inability to maintain body temperature at normal levels, the continuing hypothermia and the adipsia which he has to overcome by keeping himself warm all the time and by monitoring his fluid intake and fluid/electrolyte balance on a regular basis.

- 16.179 The skull fracture itself caused no effects except that it was depressed and damaged the duro and arachnoid mater causing the subarachnoid haemorrhage. The long-term significant effect of the fracture is the increased risk of Mr North developing post-traumatic epilepsy.
- 16.180 The impairment of memory, concentration and disturbance of sleep are related to the diffuse effects of the head injuries. In addition, the haemorrhage in the right fornix and the hypothalamic haemorrhage have contributed to these ongoing deficits. The headaches that Mr North experiences are post-traumatic headaches caused by the head injuries. The loss of sense of smell and of taste is due to damage to the olfactory nerves as a result of a direct or contra-coup frontal head injury and whiplashing of the brain in an antero-posterior direction.
- 16.181 In relation to the first head injury, Dr Loizou states that there is strong and incontrovertible evidence that Mr North suffered a head injury in an assault at 14.20 hours on the 6th September 2008. Mr North was struck on the head several times, the assailants using what appears to have been an iron bar.

16.182 Dr Loizou proposes the following sequence of events on the basis of the distribution of Mr North's external and internal brain injuries:

- i. Mr North was struck on the forehead with sufficient force whilst standing to make him fall back on his occiput which struck the hard floor. There were lacerations to the forehead and the occiput observed and treated at Hospital 3 confirming that there had been such localised impacts. Dr Loizou considers that both these injuries to the front and back of his head were significant and caused shaking of the brain and brain stem and contributed to the impairment of consciousness and unsteadiness.

- ii. Mr North was struck on the right temple with a hard implement; or he was forcibly kicked with the sole of a shoe coming down very hard, pressing the head between the foot and the floor; or Mr North had his right temple "*bashed*" hard against a protruding hard surface such as a metal door handle. This impact caused the temporal bone depressed fracture and the associated subdural and subarachnoid haemorrhage. It possibly also caused some of the intraventricular haemorrhage. This injury caused compression and displacement of the right temporal and frontal lobes to the left, thereby avulsing and rupturing one of the right middle cerebral perforating arteries which caused the main haemorrhage in the right frontal lobe. This injury was also the main causative agent for the hypothalamic haemorrhage on the right side.

- 16.183 There were other injuries to Mr North's head, some on the vertex; these were probably not responsible for any significant brain tissue damage or blood vessel rupture.
- 16.184 In relation to the second head injury, which was self-inflicted by Mr North whilst being transported in a Cat A van, Dr Loizou states that this head injury caused additional brain tissue damage through shaking of the brain and through further blood vessel rupture. In his professional opinion, it is more likely than not that the confinement of Mr North in a small space, namely the cell measuring approximately three feet by two and a half feet, together with his evolving confusion, was the basis for this abnormal behaviour.
- 16.185 The effect of the repeated banging of his head against a solid metal or plastic wall would have been to increase the antero-posterior displacement of the brain, causing an internal whiplash effect as in the shaken baby syndrome, thereby aggravating the subarachnoid, intracerebral and intraventricular haemorrhage from the arteries that were already bleeding as a result of the first injury. In addition, more perforating arteries arising from the right, middle cerebral artery ruptured, enlarging the intracerebral haemorrhage. Some of the small perforating arteries on the left side of the hypothalamus also ruptured causing more hypothalamic damage to the temperature and thirst control centres in the left hypothalamus.

16.186 It is more probable than not that this extension of the haemorrhage was the pathological basis of his continuous deterioration whilst at Healthcare in Whitemoor which, in turn, resulted in Mr North's second hospital admission a few hours later. The intracranial injuries did not pose a direct threat to life through compression and raised intracranial pressure but did so through altering the hypothalamic control mechanisms of the vital functions of temperature and fluid/electrolyte balance. His life was saved through expert and urgent treatment. The extension of the haemorrhage into the left hypothalamus around the third ventricle added to the irreversible structural damage to those brain centres which control fluid intake and thirst, temperature and sleep.

Current/permanent medical condition

16.187 Dr Loizou states that Mr North's susceptibility to hypothermia, hypernatraemia and the adipsia (lack of thirst) syndrome are due to the damage to the hypothalamic areas on the right and left side of the third ventricle.

16.188 On the balance of probabilities, the first head injury had been sufficient to cause a large amount of structural damage to the hypothalamus on the right side so as to cause the majority of the existing functional deficit. Again, on the balance of probabilities a significant proportion of the past and current deficit was caused by the second (self-inflicted) head injury which was the second head injury. The second head injury, by virtue of the way in which it was acquired, was the more likely of the two to have caused additional damage to the small arteries supplying the hypothalamus.

16.189 Dr Loizou states that it is however difficult to quantify the aggravation effect of the second head injury. For example, had the second head injury not taken place, would Mr North have had such a protracted period of being unwell during his stay at the Hospital 2 Neurosurgical Unit from the 7th September 2008 until the 3rd October 2008? Or indeed, would Mr North have gone into a second hypothermic and deranged metabolic state which caused his admission to Hospital 3 on the 18th November 2008? Or would he still be running a high (but controlled) risk of suffering hypothermia and deranged fluid/electrolyte balance?

16.190 Dr Loizou assesses the answers, on the balance of probabilities, to be as follows:

- A. Absent the effects of the second head injury, the readmission to Hospital 1 on Sunday 7th September would have happened anyway because of the progressive effects of the first injury. As stated previously, in any event, he should have been kept in Hospital 3 on first admission.

- B. Absent the effects of the second head injury, the development of the metabolic/temperature complications whilst at Hospital 2 from the 7th September 2008 until 3rd October 2008, would not have happened or if they did they would have been of a much lesser degree and certainly not life threatening.

- C. Absent the effects of the second head injury, the admission to Hospital 3 on the 18th November 2008 because of metabolic and hypothermic complications would not have happened or if it did happen, the complications would have been of a much lesser degree.

D. Absent the effects of the second head injury, the residual ongoing susceptibility to metabolic and temperature disturbances would be of much lesser degree than it currently is, and it would not be potentially life threatening.

16.191 Mr North's current susceptibility to hypothermia, hypernatraemia and adipsia is such as to continuously pose a threat to his health, in addition in later years when the ageing process begins to take effect the susceptibility to hypothermia is likely to be a definite risk factor to early death unless he has round the clock care and keeps his environment temperature under constant control.

16.192 Mr North's current and permanent neurological symptoms consist of headaches, impaired memory and concentration. These are related to diffuse damage. He also suffers from abnormalities of sleep and impairment/loss of sense of taste or smell. These are related to specific areas of damage, i.e. the olfactory bulb and fibres and the hypothalamus respectively.

Causation and attribution of metabolic and neurological deficits

16.193 At the specific request of the lead investigator, Dr Loizou has produced an estimate of causation in relation to the ongoing metabolic/temperature and neurological complaints. His professional opinions are as follows:

- 1) the metabolic and temperature symptoms are 70% due to the first injury and 30% to the second injury.
- 2) The headaches are 40% due to the first injury and 60% to the second.
- 3) The sleep disturbance is 50% due to the first injury and 50% due to the second.
- 4) The impairment of memory and concentration is 60% due to the first injury and 40% to the second.
- 5) The loss of smell and taste is 30% due to the first injury and 70% to the second.

16.194 Dr Loizou seeks to stress that the above are only estimates based on experience rather than statistical information, which in fact, does not exist for such situations.

16.195 Dr Loizou reflected as to whether the second head injury was preventable or avoidable, given that it occurred whilst Mr North was still suffering significant confusion from the first head injury whilst in the Accident & Emergency Department at Hospital 3. He is quite clear in his opinion that the second head injury occurred because staff at Hospital 3 *“failed in their duty to keep Mr North in hospital, to carry out an urgent CT head scan and refer him to the neurosurgeons at Hospital 2. Instead, he was (i) allowed to leave and (ii) in a CAT A van rather than an ambulance.”*

16.196 Dr Loizou proceeds to reiterate the following issues:

“i. As a result of the internal dimensions and structure of the cell in the CAT A van, it is improbable if not impossible that the right temporal bone fracture and the associated brain injury were acquired in the Cat A van.”

- ii. It is possible for a significant head injury to be self inflicted by the process of “head banging” against the metal frame surrounds of the door to the cell and the small windows in the door, or indeed against the hard plastic walls. Clearly, a head injury that causes unconsciousness will be self limiting, but repeated head butting which shakes an already vulnerable brain can cause primary damage or aggravate existing structural damage.*

- iii. The evidence available to me indicates very strongly that repeated head banging did take place in the cell of the Cat A transport van.”*

Prognosis

16.197 Dr Loizou concludes his detailed report by outlining Mr North's future medical prognosis. This is based upon all of the documentary evidence made available to him and his consultation and examination of Mr North on the 25th March 2011.

- i. The hypernatraemia, adipsia and hypothermia syndrome is permanent. Mr North has enough insight and enjoys excellent supervision in Prison 1 so that it is highly unlikely that any complications will emerge without them being identified in good time. The difficulties and risks will arise in future when Mr North finds himself in the community once again. As he becomes older these functions become subject to degenerative ageing processes and will therefore become more problematic, more likely to create the risk of hypothermia and hypernatraemia with serious or even fatal consequences especially in adverse whether conditions of undue heat or cold. There will therefore be a requirement for more resources to be deployed to protect Mr North's health and life.

- ii. At the time of the examination, the migraine headaches are likely to continue for a year or so before they abate; there will, however, be a tendency for them to recur every one or two years with a frequency of twenty or so attacks per year.

- iii. The memory and concentration problems will always be present, but eventually Mr North will find ways round the problems as indeed he is beginning to do now.

- iv. The loss of smell and taste is permanent.

- v. The sleep derangement is permanent but Mr North could be instructed in 'sleep hygiene', and perhaps the problem could be moderated this way.

- vi. There is a risk of developing post traumatic epilepsy as stated previously. This is currently estimated at around 5% and reducing to 2.5 – 3.0% by year ten post injury. This will then remain for the rest of his life.

vii. With regards to life expectancy, it has to be accepted that as a result of the loss of ability to maintain fluid and electrolyte balance as well as the permanent hypothermia, life expectancy will be reduced. The risk of developing post traumatic epilepsy will add further reduction to life expectancy. There is also a small but definite risk of premature aging of the brain after the age of 65. It is therefore, concluded that Mr North is currently subject to an overall 5 year reduction in life expectancy.

16.198 At the time of writing, Mr North continues to reside within the Healthcare Centre at Prison 1. As reported above, Dr Loizou considers that this environment is adequately meeting all of his immediate ongoing medical requirements.

KEY FINDING 20. **As a result of events of the 6th September 2008, both the assault on C wing and the subsequent banging of his head inside the Cat A transport van, Mr North suffered significant brain trauma. Medical evidence suggests that whilst some of his ongoing conditions may improve with time, others will clearly remain with him for life. He will almost certainly face significant challenges in later life, particularly if he needs to maintain an independent existence without the support and medical supervision that he currently receives within the prison environment. It is**

concluded that Mr North is currently subject to an overall five-year reduction in life expectancy.

KEY FINDING 21.

Whilst this investigation has identified some shortcomings in relation to a variety of systems and processes that were in place at HMP Whitemoor in 2008, all of the evidence indicates that Mr North received an appropriate standard of medical treatment whilst under the care of prison staff. This relates to staff present in the gymnasium and on C wing at the time of the two assaults through to medical staff in the Healthcare Centre.

CHAPTER 17.

NOMS INTERNAL INVESTIGATION

- 17.1 The process adopted by the lead investigator for the disclosure of documents to interested parties is covered in section 6 of Appendix A to this report. Following receipt of some of those documents, Mr North's solicitor, wrote to the lead investigator on the 25th February 2013 raising a number of issues with him. One concern in particular called into question the possible authenticity of Document 036. This is the handwritten risk assessment note that Governor 4 states that he made in a personal note book on the afternoon of Friday 5th September 2008, the day prior to Mr North's return to C wing. A section of the letter stated "*we are concerned that the note is self serving and actually written retrospectively to justify the decision, rather than representing the decision making process itself. Most significantly some of the language of the review is retrospective.*" The letter goes on to quote a few examples of where the words used by Governor 4 were in the past tense as opposed to the present. Clearly, the concern raised was that the note had been written after the second assault on Mr North as a back-covering exercise. Whilst there was no evidence to support any such suggestion, should it indeed turn out to be the case, then that would be a very serious issue not only for this investigation but for Governor 4 and NOMS in general.
- 17.2 Paragraph 9 of the lead investigator's Terms of Reference were quite clear in that they stated the following:

“If you form the view that a disciplinary investigation should be undertaken, you must alert the SSJ [Secretary of State for Justice] through SCOP [Safer Custody & Offender Policy Group]. If at any time findings emerge from the investigation which you consider require immediate action, you must alert the SSJ to those findings through SCOP.”

17.3 Given the nature of the aforementioned allegation, the lead investigator subsequently wrote to the then Acting Head of the Offender Safety, Rights & Responsibilities Group (OSRR) at the National Offender Management Service (NOMS) raising this matter with him and inviting HM Prison Service to consider conducting an independent investigation into the authenticity of the risk assessment note produced by Governor 4 (Document 036). By this time OSRR had succeeded SCOP. After some considerable period of time, NOMS agreed to appoint a Governor, who had not previously worked at HMP Whitemoor, to conduct such an investigation. Governor 11 was appointed to undertake this investigation. He was also tasked with making enquiries aimed at trying to locate the note book which was purported to contain Governor 4’s original handwritten note.

17.4 Governor 11’s investigation took place during the month of January 2014. During this period he undertook enquiries with a number of staff at HMP Whitemoor, and instigated a number of searches at the prison

in order to try to locate the original note book used by Governor 4. That book was not located and remains outstanding.

17.5 On the 9th January 2014 Governor 11 interviewed Governor 4. In response to some questions during that interview, Governor 4 gave accounts that were at odds with what he had told Article 2 investigators during their earlier, initial interview with him. He maintained that he had left his book at HMP Whitemoor when he left the prison in 2009 in order to take up an appointment in Northern Ireland, but that he had taken with him a photocopy of the entry that related to Mr North. He stated that he did this as he believed from an early stage that he might need the document for a subsequent investigation, as he knew it was a serious incident. When asked about the use of past and present tenses in the wording of his risk assessment, he stated that he could not explain this but said that it was just the way that he had written it. He insisted that the note had been written at the time and date on the document and he denied that he had written it retrospectively.

- 17.6 Governor 4 informed Governor 11 that it was he who had handed a copy of his original note to the Article 2 investigators during his first interview with them in February 2011. He stated that the investigators were unaware of its existence up until that point. This assertion by Governor 4 is incorrect as the Article 2 investigators had been provided with a copy of the document during an initial briefing with the then Governing Governor at HMP Whitemoor in May 2008.
- 17.7 Governor 11 concluded his investigation by stating that on the evidence presented he could find no reason to doubt the authenticity of Governor 4's photocopied note book entry and that it was a copy of a contemporaneous note written at the time stated. Governor 11 also concluded that as the original note book had not been located there was no person, other than Governor 4, able to confirm the veracity of the note book entry.
- 17.8 Both Governor 11's investigation report and a transcript of his interview with Governor 4 were subsequently disclosed, as per the standard processes, to all interested parties connected to this Article 2 investigation. On the 30th May 2014, following the aforementioned disclosure process, Solicitor 2 at Legal Practice 2 again wrote to the lead investigator on behalf of her client, Mr North. Her letter raised concerns about the lack of a robust and challenging approach during Governor 11's interview with Governor 4. The assertion was that Governor 11 simply took on face value the responses provided and did not seek to

introduce conflicting evidence or challenge Governor 4's statements during the interview.

17.9 Following the finalisation of Governor 11's investigation, it was clear that Mr North and his advisors remained unconvinced by the evidence being provided by Governor 4. Firstly, in relation to the decision-making process itself, who actually participated in it on the afternoon of Friday 5th September 2008? Secondly, in relation to the authenticity of the handwritten note, in essence was it actually written at the time and on the date stated in the document?

17.10 Following on from the investigation conducted by Governor 11, the lead investigator of the Article 2 investigation took the decision to conduct second interviews with both Governor 4 and Governor 7. This was in order to try to clear up ambiguities around three key issues relating to this investigation:

- i) Who participated in the risk assessment process on the afternoon of Friday 5th September 2008?
- ii) Was it possible to corroborate the fact that Governor 4 recorded his handwritten risk assessment note in his personal note book at the time and on the date stated?
- iii) What happened to the note book subsequently and where might it be now?

17.11 During the Article 2 investigators' second interview with Governor 4, on 16th July 2014, Governor 4 maintained that he made the note at the time and date stated on the document. He denied making it retrospectively in order to give some credibility and protection to his decision. He couldn't recall actually writing the note or where he was at the time. He believed that he would almost certainly have been in the Security Manager's office at the prison. Whilst stating that he could not be 100 per cent sure, he was as confident as he could be that his then deputy, Governor 7, also contributed to the decision-making process on the afternoon of 5th September 2008. Governor 4 does not believe that Governor 7 was present when he wrote the note, as he considered that having someone sit and watch him write for an hour would not be a good use of staff time.

17.12 Governor 4 also stated during the Article 2 investigators' second interview with him that he had never told anyone about him writing the note, although it transpires from our enquiries that Governor 7 was aware of its existence. Governor 4 was clear that when he left Whitemoor in 2009 in order to take up a new post at another establishment he left his book in the Security Manager's office, but he could not state precisely where, most likely in a locked cabinet. He was of the firmly-held view that Governor 7 had succeeded him as Security Manager when he moved on.

- 17.13 When challenged in interview about some of the inconsistent and conflicting answers that he had provided to some key questions during the course of three interviews, Governor 4 stated that this was partly due to the passage of time or simply down to him becoming confused over some matters.
- 17.14 In addition to questions about discrepancies around the decision to return Mr North to main location, and the authenticity of the note book, Governor 4 was asked again during this interview when he first became aware of Mr North having been assaulted on Saturday 6th September 2008. Having provided unclear and conflicting answers on previous occasions, he was unable to answer this point with any degree of certainty. Despite an initial suggestion by Governor 4 during the Article 2 investigation's first interview with him back in 2011 that he didn't know that Mr North had been assaulted until his return to work the following Monday, our enquiries have now established that Governor 4 received phone calls from the prison at home during that weekend, and that he actually visited Mr North in hospital on the evening of Sunday 7th September 2008. The bedwatch records confirming this visit have subsequently been obtained from HMP Whitemoor. These were only found at the prison in 2014, despite a request for them to be produced much earlier on in the investigation.

- 17.15 Governor 4 was very apologetic in relation to his conflicting evidence and for any confusion or difficulties that this might have caused. He did, however, make it abundantly clear that any conflict was most definitely due to lapse of memory as opposed to a premeditated attempt to deceive or mislead.
- 17.16 On Friday 12th September 2014, the Article 2 investigators interviewed Governor 7 for a second time. Governor 7 stated that he had no recollection of sitting down with Governor 4 on the afternoon of Friday 5th September 2008 and participating in a formal risk assessment process, or of being present when Governor 4 wrote the note book entry. He did, however, recall quite clearly that at around that same time he did have a number of conversations with Governor 4 about Mr North and his ongoing segregation. Not unreasonably given the passage of time, he could not recall the detail of those conversations. Enquiries have established that both Governor 4 and Governor 7 were both on duty at HMP Whitemoor on Friday 5th September 2008. The Gatekeeper's Daily Occurrence Book records Governor 4 entering the prison at 08.25 hours and leaving at 17.06 hours. Governor 7 is recorded as entering the prison at 07.30 hours. The time when he left the prison that day is not recorded. Indeed, this is the case for a number of other members of staff.
- 17.17 Governor 7 stated that he did not succeed Governor 4 as Security Manager at the prison as had been suggested by Governor 4. Governor 4's successor for a short period of time was Governor 9, and that during

that period he, Governor 7, had remained as Governor 9's deputy. When Governor 9 moved on to a new post, Governor 7 performed the role for a brief time in an acting capacity.

17.18 At some point following Governor 4's move from Whitemoor, it would appear that Governor 7, based on his account, did have possession of the note book containing the risk assessment. Governor 7 cannot recall if anyone actually handed it to him or if it was simply stored within the Security Manager's office. He stated that he did see the entry relating to Mr North in the book; however, he could not recall if he actually read it fully. He was fairly sure that he would have done. He believed that the entry relating to Mr North was not the first entry in the book, or the last. He could provide no other information in relation to this matter other than that up until that point [September 2014], for whatever reason, he believed that the book had been supplied to the Article 2 investigators at the commencement of the investigation back in 2010.

17.19 The Article 2 investigators are of the firmly-held opinion that Governor 7 presents as a very credible witness whose account, allowing for the passage of time, should be relied upon. Even when making allowances for the, at times, conflicting and confusing evidence supplied by Governor 4, Governor 7 does corroborate the existence of the blue note book and the fact that soon after the events of the 6th September 2008 he did have a conversation with Governor 4 who stated that he had made a written record of his decision to return Mr North to main location. This is particularly relevant given the fact that it was Governor 7 who

introduced Governor 4 to the practice of keeping a decision-making log in the first place. Unfortunately, where Governor 7's evidence does not assist is in corroborating exactly when Governor 4 wrote the risk assessment or clarifying what has subsequently happened to the note book containing the original note.

CHAPTER 18.

PUBLIC SCRUTINY. LEAD INVESTIGATOR'S RECOMMENDATIONS

18.1 As a consequence of this Article 2 investigation into the case of Mr North, I have concluded that there should be a subsequent public hearing at which certain issues relating to his care and management whilst at HMP Whitemoor in 2008 might be further examined.

18.2 In reaching a view on this matter I have considered two distinct issues.

- The first is whether there is a serious conflict in the evidence which needs to be tested and clarified in a public hearing.
- The second is whether the investigation has uncovered convincing evidence of widespread or serious systemic failures which require a public hearing in order to maintain public confidence.

18.3 Conflicts in Evidence

18.3.1 On this first question, my view is that there are significant conflicts, discrepancies and uncertainties around some of the key evidence. I believe that this is sufficient to justify a public hearing so that this evidence can be aired and tested in a public setting. Discrepancies in the evidence of witnesses is to be expected, especially when they are asked to provide their accounts at a time that is often some years after the actual events took place. However, the matters that I have listed below are significant and central to the main issues under investigation.

18.3.2 Each morning at HMP Whitemoor there was a management team meeting for all senior staff on duty in the prison that day. It was described as being generally of a fairly short duration, not minuted, and chaired by whoever was the most senior grade member of staff present. The purpose of the meeting, in essence, was to deal with 'here and now' operational matters. On the morning of Friday 5th September 2008 the meeting was chaired by the then Governing Governor, Governor 1. What would appear absolutely clear is that a discussion took place that particular morning about the number of prisoners currently located within the Segregation Unit at the establishment. The need to manage, and if possible reduce, those numbers was also discussed. Mr North was mentioned

by name as part of this discussion. What is far less clear is what exactly was discussed in relation to Mr North and his ongoing presence in the Segregation Unit. During witness interviews with this investigation, one group of individuals who had been present at that meeting, including amongst others Governor 2 and Governor 6, were clear in their recollection that Governor 1 appeared to have already made the decision to return Mr North from Segregation back to main location [wing]. In their view, Governor 1 simply issued an instruction to others present to make it happen.

18.3.3 That group of witnesses also described that sort of conversation as being somewhat unusual for the morning meeting, to the extent that it raised eyebrows and generated comments in the margins of the meeting once the main meeting had concluded. Another group of managers present at that same meeting have provided a very different account of what was discussed at the meeting, specifically in relation to Mr North. In essence this group, including amongst others Governor 1 and Governor 4, stated that Mr North was named in the conversation simply as an example to highlight the need to review the ongoing requirement for certain individuals to remain segregated. It was suggested by Governor 4 that his name was probably picked at random as his case was quite high profile and was subject to a legal challenge at that time. Governor 1 and Governor 4 were quite clear that an operational decision would never be made by

the Governing Governor without consultation with those people best placed to inform that decision. To suggest otherwise was described as madness, particularly in a prison like Whitemoor. The evidence of this latter group suggests that Governor 4 was tasked at the meeting with carrying out an intelligence-based risk assessment in relation to Mr North, with a view to then informing Governor 1 of the subsequent outcome. This group also described this topic as being fairly typical of the type of issue routinely discussed at the morning meetings. The two accounts provided by those present are clearly very different.

18.3.4 Whilst Governor 4 readily accepts responsibility for making the decision to return Mr North from the Segregation Unit to main location, the format of that review or decision-making process is somewhat unclear, particularly in relation to who else may have participated in or contributed to it. Governor 4 stated that he carried out the intelligence-based risk assessment between 14.30 and 15.30 on Friday 5th September 2008. This process is believed to have taken place in the Security Manager's office. In support of this account Governor 4 relied upon a handwritten note which he stated that he made in a personal note book. The lead investigator has been provided with a photocopy of the relevant pages from that book [Document 036]. This record is timed and dated as above. Within this record Governor 4 named Governor 1. In interview, Governor 1 had no personal recollection of participating in that process. During both of his

interviews with Article 2 investigators Governor 4 stated that he was as certain as he could be that his deputy, Governor 7, assisted with or contributed to the risk assessment. He is not named in the risk assessment note.

18.3.5 During interview Governor 7 had no recollection of his participation in the review on the afternoon of Friday 5th September. Although given the passage of time Governor 7's precise recollection is somewhat unclear, he was minded to conclude that he did not participate in the review discussion at that time stated by Governor 4. He does, however, state quite clearly that on a number of occasions around that same period he had a number of conversations with Governor 4 about Mr North and the subject of his ongoing segregation. Another Governor at HMP Whitemoor, Governor 5, stated in her evidence that at some point during the afternoon of Friday 5th September 2008 she had cause to go to the Security department at the prison. She describes walking into an office, most probably the Security Manager's office, and saw Governor 4 and Governor 1 in conversation. Although she took no part in the discussion, she stated that she was confident that they were talking about Mr North. It would not be unreasonable to conclude that this was likely to be the review meeting to which Governor 4 refers.

18.3.6 Governor 4 is a key witness to a number of the main issues that are central to this investigation. Legal Practice 2, the solicitors representing Mr North, formally raised their concerns around the authenticity of Document 036, following the disclosure of certain documents to them. They considered that some of the wording in the document was written in the past tense and may have been produced retrospectively by Governor 4 in order to justify his decision to return Mr North to main location. As per my Terms of Reference for this investigation, and after considering the submission from Legal Practice 2, this concern was subsequently referred to NOMS with a request that it consider commissioning a separate internal investigation into the origins of that document. NOMS subsequently commissioned its own internal investigation into this matter. The investigation was carried out by Governor 11.

18.3.7 Governor 4 maintained during that investigation, and continues to maintain, that he wrote the risk assessment at the time and on the date stated on the document. Governor 11's investigation found no evidence to suggest otherwise. Despite attempts to find the original book, it has still not been located. Governor 7 does, however, provide some testimony to support the account provided by Governor 4 that he was in the habit of using this methodology for recording his risk assessment decisions. Governor 7 also believes that at some time post these events he may have read the relevant entry, and that for a period of time he actually had ownership of the book to which Governor 4 refers.

18.3.8 During an interview with Governor 11, and two separate interviews with Article 2 investigators, Governor 4 has provided a significant amount of conflicting evidence. This conflicting evidence is not only restricted to the risk assessment issue referred to above. Governor 4 has also given different accounts to the Article 2 investigators about when and how he first knew of the fact that Mr North had been assaulted on Saturday 6th September 2008. His initial suggestion was that he found out when he returned to work at the prison the following Monday. Enquiries have, however, established that he had a number of phone calls at home from the prison prior to that Monday and indeed visited Mr North in hospital on the evening of Sunday 7th September 2008.

18.3.9 There are parts of his evidence when Governor 4, rather than being circumspect when unsure on certain matters, has initially spoken with what appeared to be a good level of knowledge and authority, only to provide a different account at a later date. When challenged on this during a second interview, he readily accepted that he had provided different accounts in relation to some of his evidence. He attributed these differences to the passage of time and the fact that he had become confused, rather than to any conscious attempt to mislead. The degree to which Governor 4's evidence can be relied upon is therefore, in my opinion, less than clear. I sense that it would be entirely reasonable, and beneficial, to revisit some aspects of his evidence at a public hearing.

18.4 **Systemic Failures**

18.4.1 With regard to the second question, as to whether any of my findings might amount to systemic failures, I am again minded to suggest that some of those findings would benefit from further exploration at a public hearing.

18.4.2 The standard of record-keeping and records management at HMP Whitemoor appears to have been somewhat inadequate back in 2008.

- i) A number of the official prison records provided to the lead investigator had either not been completed at all, or if they had, the records were either incomplete or lacked detail.

- ii) The prison was unable to provide a number of key records that the lead investigator had requested in order to support his enquiries. The lead investigator is in possession of a number of letters from managers at the prison stating that the records requested could not be located, outlining what enquiries had been made to try to locate them, and concluding that there was no realistic prospect of them ever being found. This position appears somewhat unacceptable given the duty on the prison to manage prisoner welfare and risk, plus the legal requirement to manage data in a professional manner.

- iii) It is difficult to assess what, if any, impact this may have had on either the management of Mr North or the outcome of some aspects of this investigation.

- iv) When some of these shortcomings were put to senior managers of the prison during interview, they appeared genuinely surprised and disappointed with these findings. They readily accepted that some of the failings

around records management were unacceptable and needed to improve.

18.4.3 There did not appear to be any well-developed and established systems and processes in place at HMP Whitemoor to deal with the effective and efficient management of cases involving unexplained injuries to prisoners or assaults on prisoners. From the evidence obtained from witnesses it appeared that staff across most grades did not understand their responsibilities in dealing with these types of incidents or what the wider protocol was.

- i) It would appear to be very clear that when Mr North was assaulted in the gymnasium on the 22nd July 2008 there were significant failings by a number of members of staff. The evidence that is available does not suggest that there was any attempt to secure the scene or to obtain any other forensic evidence that might have been available. No efforts appear to have been made by the Physical Education Officers present at the time to try and identify the offenders responsible for the attack. There appears to have been no investigation post the event to try to identify the offenders and thus manage any ongoing risk to Mr North. This is despite the fact that this was a serious attack that could easily have resulted in far greater injury. There appears to have been no attempt

to refer this matter to the Police for investigation although it clearly meets the ACPO / HM Prison Service agreed threshold. Indeed, only a few minutes after the attack, and whilst still being treated in Healthcare, Mr North was asked to sign a prison document stating that he did not want the matter investigated. This should not, ultimately, have been his decision.

- ii) Likewise, the level of response from the staff at the prison was very similar when Mr North was the subject of a second (and more serious) attack on the 6th September 2008. On this occasion, following the removal of Mr North to Healthcare with clearly serious injuries, his cell, which was the scene of the attack, was locked and secured. The prison search team attended in order to photograph the scene. Surprisingly, neither Green Spur nor the remainder of C wing was locked down in order to secure and preserve evidence or to assist with identifying the offenders. Staff at all grades during interview expressed their surprise that there was no immediate lockdown. Within a few minutes of Mr North being assaulted, some prisoners, who later turned out to be key suspects, were observed by officers to be acting furtively in and around the landing shower rooms on Green Spur. Those same prisoners were then seen to have changed clothing and passed other clothes through the barred

gates to fellow prisoners located on adjacent spurs. There would appear to be little doubt that this was some evidence being disposed of. Almost simultaneously, prisoners were allowed off their respective spurs in order to attend communal gym sessions in another part of the prison. The local Police did not become involved in this matter from an investigation perspective until the following day, Sunday 7th September 2008. Even then it appears that an investigation was only launched because the duty Inspector in the Police Control Room became aware that a prisoner (Mr North) was in an outside hospital with what at that time appeared to be potentially life-threatening injuries and no criminal investigation was in place.

18.4.4 Given all of the above, and after due consideration, I do take a view that a public hearing is warranted in order to provide and maintain public confidence around three main themes.

- i) How NOMS completes, manages and stores official documentation.
- ii) How NOMS identifies, manages and records evidence / intelligence in support of risk assessments when there is a possibility of a prisoner being the subject of an attack or is otherwise under threat.

iii) How NOMS, via a proportionate response, manages the scene, secures evidence, identifies attackers and liaises with the Police when a prisoner has received injuries as a result of having been assaulted.

The specific events of this case can readily be aligned to those three broad themes.

GLOSSARY OF TERMS

ABS	Anti-Bullying Strategy
ACCT Plan	Assessment, Care in Custody and Teamwork Plan: Care planning system used to help to identify and care for prisoners at risk of suicide or self-harm (replaced F2052SH Self-harm at Risk Form)
ACPO	Association of Chief Police Officers
Accumulated Visits	Convicted prisoners may save their visits entitlement. This is known as Accumulated Visits. A prisoner is eligible to apply for Accumulated Visits six months after transfer from the local prison to which he/she was sent on conviction, though earlier transfer may be possible in appropriate cases with the consent of the Governor and, in the case of Category A prisoners, of NOMS Headquarters. Prisoners may apply for further Accumulated Visits every six months, provided they have a minimum of six months to serve. Accumulated Visits may be of particular interest to those whose families are located some distance from the prison or for those families who might be ineligible for financial assistance under the Assisted Prison Visitors Scheme.
Category A	The category of prisoners whose escape would be highly dangerous to the public or the police or the security of the state, no matter how unlikely that escape might be, and for whom the aim must be to make escape impossible
Category B	The category of prisoners for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult
CC	Cellular confinement
CCTV	Closed circuit television
CALM	Controlling Anger & Learning to Manage - It aims to reduce aggressive & offending behaviour related to poor emotional management through teaching skills, emotional management techniques

CMU	Crime Management Unit
C-NOMIS	Computerised National Offender Management Information System, now known as Prison-NOMIS. It is a single national database of offender information and provides a single and consistent source of information for enquiries and reporting.
CPS	Crown Prosecution Service
CSC	Close Supervision Centre
CSCP	Cognitive Self Change Programme - Violence programme for high risk repetitively violent offenders
DHSP	Directorate of High Security Prisons OR Director of High Security Prisons
DSPD	Dangerous and Severe Personality Disorder
DST	Dedicated Search Team
ECR	Emergency Control Room
ED	Evening duty
ERDG	Equality, Rights and Decency Group
ETS	Enhanced Thinking Skills, an accredited offending behaviour programme that addresses thinking and behaviour associated with offending with the objective of reducing general reconviction rates
GOAD	Good Order and Discipline
GOOD	Good Order or Discipline
IC	In charge
IEP	Incentives and Earned Privileges
IMB	Independent Monitoring Board (formerly Board of Visitors)
IMR	Inmate Medical Record
IOCA	Interception of Communications Act
IRS	Incident Reporting System
JR	Judicial Review

KPT	Key Performance Target
LBB	Locks, bolts and bars – daily check of the physical security of a cell / wing
LIDS	Local Inmate Data System – now replaced by PRISON-NOMIS
MIU	Major Investigation Unit
MIT	Major Investigation Team
MoU	Memorandum of Understanding
MOI	Method of Injury
NOK	Next of Kin
NOMS	National Offender Management Service, an executive agency of the Ministry of Justice
NOU	National Operations Unit
OMU	Offender Management Unit
OP	Own Protection
Ops Gp	Operations Group
OSG	Operational Support Grade
OSRR Group	Offender Safety, Rights and Responsibilities Group; part of NOMS. OSRR is now replaced by Equality, Rights and Decency Group.
PEO	Physical Education Officer
PER	Prisoner Escort Record
PGA	Prison Governors' Association
PIN	Personal Identification Number
PLO	Police Liaison Officer
PNC	Police National Computer
PO	Principal Officer
POA	Prison Officers' Association

Rule 39 Within the Prison Rules, Rule 39 states that a prisoner may correspond with his legal adviser and any court and such correspondence may only be opened, read or stopped by the Governor in accordance with the provisions of this Rule.

Rule 45 Prison Rule 45. Good Order or Discipline [GOOD].
The Prison Rule under which a prisoner may be segregated or removed from association for reasons of maintaining good order and discipline or for the prisoner's own protection.

Rule 52 Rule 52 details defences to rule 51(9) which is that a prisoner is guilty of an offence against discipline if he is found with any substance in his urine which demonstrates that a controlled drug has, whether in prison or while on temporary release under rule 9, been administered to him by himself or by another person (but subject to rule 52).

Rule 52 states that it shall be a defence for a prisoner charged with an offence under rule 51(9) to show that:

(a) the controlled drug had been, prior to its administration, lawfully in his possession for his use or was administered to him in the course of a lawful supply of the drug to him by another person;

(b) the controlled drug was administered by or to him in circumstances in which he did not know and had no reason to suspect that such a drug was being administered; or

(c) the controlled drug was administered by or to him under duress or to him without his consent in circumstances where it was not reasonable for him to have resisted.

Seg	Segregation Unit
SEAP	Security Equipment Assessment Panel
SIR	Security Information Report
SMARG	Segregation Management Review Group
SOCA	Serious Organised Crime Agency
SOCO	Scene of Crime Officer
SPOC	Single point of contact
SSU	Special Secure Unit
SuffDOC	Suffolk Doctors On Call

Tariff Date	Minimum period of time set by sentencing Court that a life sentence prisoner must serve to satisfy retribution
URN	Unique reference number
VP	Vulnerable prisoner
VPU	Vulnerable Prisoner Unit
YOI	Young Offender Institution

GLOSSARY OF MEDICAL TERMS

Medical term	Definition
A	
Adipsia	lack of sense of thirst
Amitriptyline	an antidepressant drug with a sedative effect
Amnesia	<p>a condition which affects long-term memory (where information is retained indefinitely) rather than short-term memory (where it is only retained for seconds or minutes)</p> <p>'Amnesia' can also be used to mean loss of memory before and after an event. For example, after a head injury "<i>retrograde and post-traumatic amnesia</i>" means loss of memory for a period of time before and after the head injury.</p> <p>* amnesic: suffering from amnesia</p>
aneurysm	abnormal dilation (ballooning) of an artery caused by the pressure of blood flowing through a weakened area
angiogram	an X-ray film or image of the blood vessels
anterior	relating to the front of the body
anterior cruciate ligament	<p>a cruciate ligament which is one of the four major ligaments of the human knee. It is one of the two ligaments in the knee that pass over each other to form a cross. They form connections between the femur* and tibia* inside the knee joint and prevent over-bending and over-straightening at the knee.</p> <p>* femur: thigh bone, the bone in the leg closest to the body</p> <p>* tibia: shinbone, the larger and stronger of the two bones in the leg below the knee</p>

anteriorly	in an anterior direction. See the definition for anterior above.
anterior horn	<p>The spinal cord has a central core of nerve cell bodies which is in the shape "H"; each "leg" of the H is referred to as a "horn". The lower part of the H points towards the front (anteriorly) and so is known as the anterior horn(s) and contains motor neurons*. The legs at the top point posteriorly are known as the posterior horns and contain sensory neurons. In the thoracic spine* and part of the lumbar spinal cord* there are, in addition, lateral horns which protrude from the horizontal line of the H; they contain autonomic system nerve cell bodies.</p> <p>In the brain, the main lateral ventricles have an anterior expansion known as the anterior or frontal horn of the left or right lateral ventricle; and there is also a posterior or occipital horn of the left and right lateral ventricles. Each lateral ventricle has an anterior and a posterior horn and a body between the two; it also has an inferior or temporal horn (because the inferior horn goes into the temporal lobe).</p> <p>* neuron: see the definition</p>
antero-posterior	a line running from front to back
anterior-posterior	as above
aqueduct	<p>This is the part of the brain ventricular system* which is literally a small pipe (= aqueduct) connecting the third ventricle anteriorly with the fourth ventricle posteriorly. [The two lateral ventricles connect with, and empty their watery content into, the third ventricle which is in the midline. The third ventricle continues into the aqueduct which runs backwards to connect with the fourth ventricle, which then empties its watery content (CSF)* into the cisterna magna, a large space at the junction between the back of skull and the cervical spine.]</p> <p>* See the definition of ventricle.</p> <p>* CSF: cerebrospinal fluid. A clear, watery fluid that circulates between the ventricles (cavities) within the brain, the central canal in the spinal cord, and the space between the brain and spinal cord and their protective coverings, the meninges.</p>

arachnoid mater	a delicate fibrous membrane forming the middle of the three coverings of the central nervous system. One of three membranes (<i>meninges</i>) that encase the brain and spinal cord. The arachnoid mater is the middle membrane.
ataxia	inco-ordination and clumsiness that affects balance and gait limb or eye movements, and/or speech. Ataxia may be caused by damage to the cerebellum* or to nerve pathways in the brainstem* and spinal cord. * See the definition of cerebellum. * See the definition of brainstem.
atrophy	the wasting away or shrinkage of a normally developed tissue or organ that results from a reduction in the size or number of its cells
avulse	to pull off or tear away forcibly
B	
basal ganglia	group of nerve cells within the brain that are concerned with control of limb and body movements. The basal ganglia play a vital part in producing smooth, continuous muscle action and in stopping and starting movement. Any disease or degeneration affecting the basal ganglia and their connections may lead to the appearance of involuntary movements, trembling, stiffness and slow movements (and sometimes weakness), as occur in Parkinson's disease.
bilateral	a term that means affecting both sides of the body, or affecting both organs if they are paired (for example, both ears in bilateral deafness)
blackout	a temporary loss of memory or consciousness. (The term is sometimes used to refer to loss of vision.)
BP	blood pressure
bpm	beats per minute
bradycardia	abnormally slow heart rate

brainstem	a stalk of nerve tissue that forms the lowest part of the brain and links with the spinal cord
C	
cardiovascular	pertaining to the heart and blood vessels
cavum septum pellucidum	a <i>cavum</i> is a hollow or space, or a potential space, within the body or one of its organs. A septum is a dividing wall or partition. In the human brain, the cavum septum pellucidum is the median cleft between the two laminae of the septum pellucidum*. It is a slit-like, fluid-filled space of variable width between the left septum and the right septum.
cerebellar	literally means “of the cerebellum”.* in certain types of brain disorder, a collection of symptoms, due to damage to the cerebellum, its projections and its connections that includes tremor, speech disturbance, and abnormal eye movements and gait * See the definition of cerebellum.
cerebellum	a region of the brain behind the brainstem concerned with maintaining posture and balance and coordinating movement
cerebral	of, or relating, to the brain or cerebrum* * cerebrum: the largest and most developed part of the brain, the site of most conscious and intelligent activities
cognitive	pertaining to the mental processes of perception, memory, judgement, and reasoning, as contrasted with emotional and volitional processes
concussion	brief unconsciousness due to disturbance of the electrical activity in the brain following a violent blow to the head or neck

contrecoup	an injury to the part of the brain diagonally opposite to the actual site of injury, for example a direct injury to the front of the head. For example, the front of the head hits a wall; damage is caused to the front of the brain as it hits the inside of the skull – this is referred to as the coup injury; then the brain travels backwards and the back end of the brain hits the inside of the occipital skull* and develops a contusion injury. This is called contrecoup injury.
contusion	bruising to the skin and underlying tissues from a 'blunt' injury such as an impact. It is also used to describe a blunt injury to the brain tissue.
coronal plane	<p>the plane which cuts through the body in a front to back (antero-posterior) direction. This plane is what one sees when one takes a frontal photograph of the body: two eyes, two ears, the whole face and the whole frontage of the body. As the plane moves backwards, one begins to see the hidden parts of the body. The coronal plane shows the left, right and middle of the body.</p> <p>The other two planes are the sagittal plane, cutting from side to side, i.e. giving a lateral profile view, and the axial or horizontal plane which cuts the body from top to bottom like serial slices of bread.</p>
cortisol	<p>alternative name for hydrocortisone, a corticosteroid hormone* that is produced by the adrenal glands</p> <p>* See the definition of corticosteroid hormones.</p>
cortex (plural: cortices)	the outer layer of certain organs, such as the brain or kidneys. The cortex of the brain is rich in nerve cells and called grey matter.
cortical	of the cerebral cortex
corticosteroid hormones	The corticosteroid hormones are a group of hormones produced by the adrenal glands that control the body's use of nutrients and the excretion of salts and water in the urine.
cortisone	<p>a corticosteroid hormone* that is produced synthetically</p> <p>* See the definition of corticosteroid hormones.</p>

cranial	<p>of, or relating to, the skull or cranium*</p> <p>* cranium: the part of the skull around the brain</p>
cranial nerves	<p>twelve pairs of nerves that emerge directly from the underside of the brain. Each of the nerves has a number as well as a name. The numbers indicate the sequence in which the nerves emerge from the brain. The main function of some cranial nerves is to delivery sensory information from the ears, nose, and eyes to the brain. Some are also motor and move the eyes, the face, the jaws, the mouth, the tongue and the neck.</p>
creatinine	<p>a waste product produced by muscles and filtered from the blood by the kidneys to be excreted in urine</p>
CT angiogram	<p>a computed tomogram (a cross-sectional image) which shows the arteries or veins of a particular area being scanned</p>
CT scan	<p>computerized axial tomographic* scan (CT scan is the colloquial name for CAT scan. CAT scan is the more formal acronym.)</p> <p>a diagnostic technique in which the combined use of a computer and X-rays produces cross-sectional images of tissues. It may be used in the diagnosis and treatment of tumours, haemorrhages et cetera in the brain, as well as head injuries and strokes, and to locate tumours and investigate diseases.</p> <p>* tomography: Radiological technique for obtaining clear X-ray images of internal structures by focusing on a specific plane within the body to produce a cross-sectional image. It allows the examination of structures that are obscured by overlying organs and soft tissues and do not show up clearly on conventional X-ray images. (<i>Tome</i> is Greek and means a <i>slice</i> or <i>cutting through</i>; <i>graphe</i> is Greek and means writing; tomography is the writing of a slice or the image one obtains when one cuts through a particular slice).</p>
D	
defence wound	<p>a wound sustained when a victim places a hand (often the palms), arm (lateral forearms) or other body part in harm's way to prevent or minimise the impact of a blow or slashing by a sharp weapon</p>

dehydration	a condition in which a person's water content is at a dangerously low level
deranged metabolic state	the state of the body when all the fluid and electrolytes*, such as sodium and chloride, and other nutrients such as glucose and amino acids, and the acid content of the body et cetera are completely outside their normal range of concentration *electrolyte: See within the definition of electrolyte balance.
diabetes insipidus	a rare condition that is characterised by excessive thirst and the passing of large quantities of dilute urine which is not caused by a high blood sugar
dura mater	the outermost and most fibrous of the three membranes surrounding the brain and spinal cord. The dura mater encephali covers the brain; the dura mater spinalis covers the spinal cord.
dysphasia	a disturbance in the ability to select the words with which to speak and write and/or to understand speech or writing. It is caused by damage to speech and comprehension regions of the brain.
E	
ECG	electrocardiogram, a method of recording the electrical activity of the heart muscle. Useful for diagnosing heart disorders.
electrolyte balance	when there exists in the body the correct concentration of small molecules of salts and ions, e.g. potassium, sodium, magnesium, calcium et cetera, required by cells to regulate the electric charge and flow of water molecules across the cell membrane.
encephalomalacia	softening of brain tissue, usually caused by vascular insufficiency or degenerative changes
endocrine	the endocrine system is the collection of glands around the body that produce hormones (chemical substances necessary for normal body functioning). Hormones that are produced by these glands are responsible for numerous bodily processes, including growth, metabolism, sexual development and function, and response to stress.

endocrinologist	clinician who is familiar with the endocrine system, or hormonal system, including the investigation and treatment of its disorders
ENT	ear, nose and throat. ENT is the branch of medicine and surgery that specialises in the diagnosis and treatment of ear, nose, throat, and head and neck disorders.
epilepsy	a tendency to have recurrent seizures. Seizures are defined as transient neurological abnormalities that are caused by abnormal electrical activity in the brain.
F	
flexor	the muscle which bends a joint
fluid/electrolyte	Fluid is water between cells and tissues: urine, cerebrospinal fluid, tears, saliva, gastric juices. Electrolytes are positively or negatively charged ions. For example, Na ⁺ is sodium ion electrolyte, H ⁺ is hydrogen ion. Electrolyte is in fluid, e.g. urine.
frontal (lobe)	a term referring to the front part of an organ (for example, the frontal lobe of the brain)
focal motor loss	loss of power or of movement which affects a specified (i.e. focal) part, for example, inability to bend the right elbow.
fornix	a bundle of fibres in the brain which run between the mamillary bodies and the hippocampus of the temporal lobe
fourth ventricle	The brain has four ventricles [cavities]: one in each of the two cerebral hemispheres; a third at the centre of the brain, above the brainstem; and a fourth between the brainstem and cerebellum.
G	
Glasgow Coma Scale	reliable and universally-recognised method for assessment of conscious level following head injury. Three types of response are measured: best motor response (score 1 - 6), best verbal response (1 - 5) and eye opening (score 1 - 4). The lowest score is 3 (1 in each category). A GCS of 8 or less indicates severe injury, 9 - 12 moderate injury and 13 - 15 a mild injury.

gliosis	<p>proliferation of neuroglia* in the brain or spinal cord, either as a replacement process or in response to a low-grade inflammation</p> <p>* neuroglia: the non-nervous, supporting elements of the nervous system</p>
gliotic cavity	<p>a hollow, i.e. cavity, inside a gliotic formation. Glia are the 'packing' cells of the brain and spinal cord which give supporting structure to the nerve cells (= neurons). Whenever there is injury or damage to the brain and spinal cord, the glial cells come together to form a 'gliotic scar' which sometimes cavitates and contains protein-rich fluid. A gliotic cavity can sometimes be empty.</p>
gradient echo imaging	<p>a type of image obtained using a specific sequence of the magnet in an MRI scan (which therefore gives a specific image)</p>
H	
haematoma	<p>a localised collection of blood (usually clotted) that is caused by bleeding from a ruptured blood vessel</p>
haemorrhage	<p>bleeding</p>
haemosiderin	<p>a yellow or brown protein produced by phagocytic* digestion of hematin (a blue to blackish-brown compound formed in the oxidation of haemoglobin and containing ferric iron); found in most tissues, but especially in the liver</p> <p>* phagocyte: a cell in the immune system that can surround, engulf and digest microorganisms, foreign particles and cellular debris. Phagocytes are found in the blood, spleen, lymph nodes, and alveoli (small air sacs) within the lungs.</p>
hallucination	<p>perception of visual, auditory, tactile, olfactory, or gustatory experiences without an external stimulus and with a compelling sense of their reality, usually resulting from a mental disorder or as a response to a drug</p>
heart block	<p>a common disorder of the heartbeat caused by an interruption to the passage of impulses through the heart's conducting system. There are several grades of heart block.</p>

hydrocephalus	a condition that occurs when there is too much cerebrospinal fluid in the ventricles (cavities) of the brain
hydrocortisone	a steroid which may be used to treat inflammation
hypernatraemia	higher than normal concentration of sodium in the blood due to excessive water loss or inadequate water intake
hypoadrenalism	<p>1. reduced function of both the cortices and medullae of the suprarenal gland.</p> <p>2. reduced adrenal cortical function</p> <p>The cortex* of the suprarenal glands produces the hormone cortisone; the medulla, i.e. the centre of the gland, produces the substance adrenaline. A human being needs both to stay alive: the cortisol maintains the metabolism and the adrenaline stimulates the heart to act more powerfully and brings the blood pressure up; it stimulates activity. Usually, it is the cortex that fails, rarely the medulla.</p> <p>* cortex: See the definition.</p>
hypopituitarism	<p>the loss of function in an endocrine gland* due to failure of the pituitary gland to secrete hormones which stimulate that gland's function. The pituitary gland is located at the base of the brain. It produces several hormones whose function is to stimulate glands elsewhere in the body to produce and secrete their hormones. When the pituitary gland fails to produce its hormones, then several changes occur in the body which are collectively referred to as hypopituitarism; for example, the thyroid gland fails and the body slows down, the gonads fail and there is sterility et cetera.</p> <p>* endocrine gland: a ductless gland, such as the pituitary, thyroid, or adrenal gland, that secretes its hormones directly into the blood or lymph nodes, affecting metabolism and other body processes</p>

hypothalamus	<p>The hypothalamus is a small area of the forebrain. It is situated behind the eyes, under the thalamus and above the pituitary gland.</p> <p>The hypothalamus controls the sympathetic nervous system (part of the autonomic nervous system). In response to sudden alarm or excitement, signals are sent from higher regions of the brain to the hypothalamus, initiating sympathetic nervous system activity.</p> <p>Other nerve cells in the hypothalamus are concerned with the control of body temperature, thirst and appetite for food. The hypothalamus is also involved in regulating sleep, motivating sexual behaviour, and determining mood and emotions. It indirectly controls many endocrine glands through its influence on the pituitary gland.</p>
hypothermia	<p>a fall in body temperature to below 35° C. The body loses its sensitivity to cold as it ages, becoming less able to reverse a fall in temperature.</p> <p>* hypothermic: relating to, or suffering from, hypothermia</p>
hypothyroid	<p>suffering from hypothyroidism, i.e. the underproduction of thyroid hormones due to underactivity of the thyroid gland. These hormones are important in metabolism and a deficiency therefore causes many of the body's functions to slow down.</p>
I	
inco-ordination/ataxia	<p>Inco-ordination is the English word for the Greek word <i>ataxia</i>* (adopted into English) which means lack of order.</p> <p>* ataxia: inco-ordination and clumsiness that may affect balance and gait, limb and eye movements, and or speech. Ataxia may be the result of damage to the cerebellum (the part of the brain concerned with coordination).</p>
insula	<p>a pyramid-shaped area of the brain within each cerebral hemisphere beneath parts of the frontal and temporal lobes</p>
inter-digital web space	<p>the soft flat tissue that runs between two fingers or two toes</p>

internal capsule	a large fibre tract in the basal ganglia which carries motor fibres from the cortex to the brainstem and spinal cord and which also has fibre tracts coming up from the spinal cord and the limbs et cetera, bringing in sensory information to the cerebral cortex and thalamus bilaterally
intracerebral haemorrhage	bleeding into the tissue of the brain from a ruptured blood vessel
intracranial	occurring or situated within the cranium (the skull)
intraparenchymal	within the parenchyma* of an organ. * parenchyma: the essential or functional (as opposed to supporting) tissue of an organ
intraventricular	within or between ventricles [cavities] of the brain
J	
J wave	a deflection occurring in the electrocardiogram between the QRS complex* and the onset of the ST segment*, occurring prominently in hypothermia and in hypocalcaemia* * QRS: the electrical complex shown on the ECG (electrocardiogram) as an up =Q then down =R and then up =S deflection representing the period of contraction of the ventricles of the heart * ST segment: a straight (= horizontal) line from the last point of the S wave (which is at the zero horizontal position) to the start of the T wave which is an upward semicircular elevation above the horizontal line and represents depolarization – relaxation of the ventricular muscles. (When the ST segment is elevated it signifies a heart attack.) * hypocalcaemia: an abnormally low level of calcium in the blood
K	

L	
laceration	a torn, irregular wound
lateral ventricle	<p>Also see the definition of ventricle.</p> <p>The lateral right and left ventricles of the brain are the large cavities in the cerebral hemispheres which are filled with cerebrospinal fluid and which extend from the frontal to the parietal lobes in the shape of a slightly curved, elongated balloon. The ventricles are separated by a thin membranous structure (the septum pellucidum) and they drain their fluid content through the right and left foramen of Monro into the midline-placed third ventricle, which continues backwards through a small curved channel (the aqueduct) into the fourth ventricle in the pons and medulla of the brainstem. The fluid drains into the cerebrospinal fluid space of the spinal canal through the foramina of Luschka and Magendie.</p> <p>It has been found that stem cells from a certain region in the brain, called the forebrain lateral ventricle (LV), are able to generate new nerve cells.</p>
lesion	an all-encompassing term for any abnormality of structure or function in any part of the body. The term may refer to a wound, infection, tumour, abscess, or chemical abnormality.
long-term memory	in psychology, that section of the memory storage system in which experiences are stored on a semi-permanent basis
M	
Maxolon	<p>brand name for metoclopramide. Metoclopramide has a direct action on the gastrointestinal tract, stimulating the smooth muscle to contract, and thereby initiates or improves motility*. It is used for conditions in which there is a need to encourage normal propulsion of food through the stomach and intestine.</p> <p>It also has antiemetic* properties and its most common use is in the prevention and treatment of nausea and vomiting. It is particularly effective for the relief of the nausea that sometimes accompanies migraine headaches.</p>

	<p>*motility: ability to move spontaneously and independently</p> <p>*antimetic drugs: a group of drugs used to treat nausea and vomiting</p>
medulla (plural: medullae)	<p>the innermost part of an organ or other body structure.</p> <p>In neuro-anatomy, the term 'medulla' is a shortening of the proper term 'medulla oblongata' which is the lowest part of the brain and is located in the part of the skull referred to as the posterior fossa (the back of the head, sitting on top of the neck between the ears). The medulla oblongata is the extension of the central nervous system from the uppermost part of the cervical spinal cord and it continues upward into the pons and then into the mesencephalon or midbrain. Together, these three structures are referred to as the brainstem. All the tracts which connect the cerebral hemispheres with the spinal cord pass through the medulla oblongata, which also contains the respiratory centre and cardiac control centres in addition to the control nuclei for articulation, voice production and swallowing et cetera. Severe acute damage to the medulla oblongata leads to immediate death as in hanging.</p>
metabolic state	<p>This is an all-encompassing term which refers to the state of energy production and consumption in any part of the body, the utilisation of simple substances such as amino acids for production of proteins, sugars for the production of carbohydrates et cetera; it also refers to the breakdown of substances, the clearing processes of unwanted substances through the liver and the kidneys, the production of hormones, enzymes, secretions (for example, in the stomach and intestine), the production of heat for maintenance of body temperature, the maintenance of fluid and electrolyte balance and maintenance of the acid-base balance, i.e. the <i>pH</i>.</p>
MRI scan	magnetic resonance imaging scan of the head
N	
neoplasm	a medical term for a tumour (any new abnormal growth). Neoplasms may be cancerous or noncancerous.
neurology	the medical discipline concerned with the study of the nervous system (including the muscular system) and its disorders

neuron	a nerve cell, a specialized cell transmitting nerve impulses
O	
occipital horns	<p>The occipital horns are posterior extensions of the lateral ventricles which occupy the centre of the right and left occipital lobes of the brain; they contain cerebrospinal fluid. The cortical* tissue around the occipital horns contains fibre tracts and neurons* which are part of the visual system and of the visual association system, including face recognition and visual memory.</p> <p>one of the two areas of brain tissue that lie beneath the occipital bone at the back of the brain. Primarily concerned with vision</p> <p>* cortical: of the cerebral cortex</p> <p>* neuron: See the definition.</p>
occiput	the lower back part of the head, where it merges with the neck
oedema	abnormal fluid accumulation in body tissues that may be localised (as in swelling from an injury) or generalised (as in heart failure). Symptoms of generalised oedema, such as swelling around the base of the spine and in the ankles, occur when excess body fluid increases by more than 15 per cent.
olanzapine	Olanzapine is an atypical antipsychotic drug prescribed for the treatment of schizophrenia and mania and for long-term treatment of bipolar disorder.
olfactory bulb	the swelling at the end of each olfactory nerve that deals with the sense of smell. These bulbs lie on the brain's lower surface, just above the roof of the nose.
olfactory fibres	These are the individual projections from individual nerve cells in the olfactory bulbs which come through tiny holes the base of the skull above the nose and which end up in the lining of the nose, extending into special receptors which respond to odour produced by molecules of substances sucked in with the inspired air. They are the peripheral projections of the olfactory nerve cells, the central projections of which make up the olfactory nerves or tracts which end in the medial temporal lobes. These peripheral fibres are commonly damaged in head injuries and account for the loss of the sense of smell (and taste) after head injuries.

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olfactory nerve [singular]	The olfactory nerve is the first cranial nerve which conveys sensations of smell as nerve impulses from the nose to the brain.
olfactory nerves [plural]	There are two olfactory nerves. Each of nerves has receptors that detect smells and send signals along nerve fibres
Opsite	a semipermeable adhesive film dressing. Opsite is a brand name.
osmolality	the concentration of a solution in terms of osmoles of solute per kilogram of solvent. Disturbances of concentration and osmolality of substances (especially of electrolytes such as sodium, potassium, magnesium, calcium et cetera) can cause severe disturbances in the generation of electricity in the nervous system and muscles, such as epileptic fits, confusion, drowsiness or coma and twitching or cramps of spasms or extreme weakness in muscles.
P	
paracetamol	an analgesic drug that is used to treat mild pain and to reduce fever
paranoid	suffering from paranoia, a condition in which the central feature is the delusion that people or events are especially connected to oneself. The term paranoia may also be used to describe feelings of persecution.
Paramax	combined preparations of paracetamol and metoclopramide. Metoclopramide has a direct action on the gastrointestinal tract. It is used for conditions in which there is a need to encourage normal propulsion of food through the stomach and intestine. Paramax is almost exclusively used in the treatment of acute migraine attacks.
pathological	relating to disease or to its study (pathology)

<p>perforating arteries</p>	<p>This term refers to arteries which go through a part of the body to end up at a point beyond which they do not join any other arteries (like the fingers of the hand). In the brain this term refers to a group of arteries which arise from the middle cerebral or anterior cerebral or basilar arteries and supply specified small areas of the brain. When a perforating artery is occluded the corresponding part of the brain to which it supplies blood suffers infarction* and dies. Small perforators also develop aneurysmal* dilatations which often rupture, usually under conditions of hypertension, and cause small or large intra-cerebral haemorrhages.</p> <p>* infarction: death of any tissue due to lack of blood supply</p> <p>* aneurysmal: pertaining to an aneurysm. See the definition of aneurysm.</p>
<p>Perisylvian region</p>	<p>The Perisylvian is the region of the brain around the Sylvian fissure. The Sylvian fissure is within the cerebrum, the largest body of the brain. The Perisylvian region is on the surface of the brain and holds the majority of language tissue.</p> <p>The Sylvian fissure is a space filled with cerebrospinal fluid which medially separates the temporal lobe of the brain from the underlying cortical* tissue referred to as the insula and hypothalamic/diencephalic area* and anteriorly from the frontal lobe. The cortical areas around this space are referred to as the Perisylvian region and their functions include receptive and expressive language and speech.</p> <p>* cortical: of the cerebral cortex</p> <p>* diencephalic: relating to the diencephalon. The diencephalon is the posterior part of the forebrain that connects the midbrain with the cerebral hemispheres, encloses the third ventricle, and contains the thalamus and hypothalamus.</p>

<p>pituitary gland</p>	<p>Sometimes referred to as the master gland, the pituitary is the most important of the endocrine glands (glands that release hormones directly into the bloodstream). It regulates the activities of other endocrine glands and many body processes.</p> <p>The pituitary (or hypophysial) gland is found in the midline at the base of the brain in a small saccular depression of the skull referred to as the sella turcica (Turkish saddle). It is attached to the infundibular stem (or stalk) which arises from the median eminence at the base of the hypothalamus. It has two parts:</p> <ul style="list-style-type: none"> - the anterior which produces several pre-hormones, i.e. hormones which act on effector endocrine cells in the body, for example the thyroid gland, to produce a hormone, e.g. the thyroid hormone (or thyroxine) - the posterior part which produces one hormone referred to as the anti-diuretic hormone which acts directly on the kidney to restrict the amount of water which is excreted in the urine.
<p>plantar</p>	<p>of, or pertaining to, the sole of the foot</p>
<p>platelet</p>	<p>smallest type of blood cell. Platelets play a major role in blood clotting.</p>
<p>pons</p>	<p>the middle part of the brainstem</p>
<p>post-traumatic amnesia</p>	<p>loss of memory of events after the moment of head injury; it may last a few seconds to several months.</p> <p>PTA: post-traumatic amnesia. PTA may last less than one hour; in the case of a moderate head injury PTA lasts 1 – 24 hours or in the case of a severe head injury PTA lasts longer than 24 hours.)</p>
<p>potassium</p>	<p>a metallic mineral needed to help maintain normal heart rhythm, regulate the body's water balance, conduct nerve impulses, and contract muscles</p> <p>A low level of potassium in the blood causes fatigue, drowsiness, dizziness, and muscle weakness. In severe cases, there may be abnormal heart rhythms and muscle paralysis.</p>

Q	
R	
retrograde amnesia	in retrograde amnesia, the loss of memory extends back from some time before the onset of the event which caused it (invariably a head injury).
right frontal lobe	The frontal lobe is the front part of the cerebral hemisphere; it is the largest part of the brain in terms of volume and area. There are two hemispheres, right and left, hence a right and a left frontal lobe.
right lateral ventricle	See the definition of lateral ventricle.
right temporal bone	the right and left temporal bones form the sides of the human skull. Each of the pair of temporal bones is a thin vine-leaf-like bone part of the skull above the ear. It joins with the frontal bones (anteriorly), parietal bones (superiorly), and occipital bones (posteriorly).
right temporal pole	the anterior tip of the right temporal lobe of the brain
right temporal skull	right temporal bone [See the definition of this term.] (Right temporal skull is not an official term.)
right ventricle	right lateral ventricle (Right ventricle is short for right lateral ventricle.) See the definition of lateral ventricle.
rostra midline	Rostral means anterior; midline means the line which bisects a structure; so rostral midline refers to the front part of a midline. It is a term used for convenience.
rupture	a complete break in a structure. It is also a common term for a hernia.
S	
sciatica	a set of symptoms including pain that may be caused by general compression and/or irritation of one of five spinal nerve roots that give rise to each <u>sciatic nerve</u> , or by compression or irritation of the left or right or both sciatic nerves. The pain is felt in the lower back, buttock, and/or various parts of the leg and foot.

septum	a thin dividing wall within or between parts of the body
serial seven calculations	serial sevens test. In neurology, a test of subtracting 7 from 100, from 93, from 86, et cetera, to test attention and calculation as part of assessing higher mental functions rather than consciousness. This test is also used when administering general anaesthesia pre-surgery to see how long it takes for the brain to lose the function of attention/awareness.
serum	the clear fluid that separates from blood when it clots
shaken baby syndrome	A syndrome in infants in which brain injury is caused by shaking of such violence that the child's brain rebounds against the skull, resulting in bruising, swelling, and bleeding of the brain and often leading to permanent, severe brain damage or death.
short-term memory	<p>the part of memory which stores information arising from ongoing events from minute to minute and from hour to hour. In practice, information arising or generated in a 24 – 36 hour period is retained in the short-term memory. Short-term memory capacity varies from person to person and often fails with advancing age. A normal person is expected to remember most of the events and information generated in the previous 24 – 36 hours.</p> <p>the memory storage system of limited capacity (approximately seven items) that is capable of storing material for a brief period of time. Most of the information kept in short-term memory will be stored for approximately 20 to 30 seconds.</p>
sinus bradycardia	<p>a slow, but regular, heart rate (fewer than 60 beats per minute) that is the result of reduced electrical activity in the sinoatrial node*.</p> <p>* sinoatrial node: the natural pacemaker of the heart</p>
sleep hygiene	Sleep hygiene is a series of practical steps and non-medical treatments that may be conducive to putting oneself in the right frame of mind for sleep and for getting the right amount and quality of sleep. The steps include, for example, maintaining a regular sleep schedule and a pre-sleep routine,
sodium	a mineral that helps to regulate the body's water balance and maintain normal heart rhythm

sphincters	a ring of muscle around a natural body opening or passage that regulates inflow or outflow, such as the anal sphincter
subarachnoid bleeding	a type of brain haemorrhage in which a blood vessel ruptures and blood leaks into the space between the inner and middle meninges (membranes lining the brain, i.e. the pia which is closely applied on the surface of the brain and the arachnoid which lies between the pia and the thicker outer layer meninges, referred to as the dura, which lies immediately below the skull bones).
subdural	The subdural space lies between the inner surface of the dura and the outer surface of the arachnoid meninges; it is a virtual space which becomes evident when there is collection of fluid such as blood (i.e. subdural haematoma, as occurs after a head injury) or infection.
subgaleal haematoma	bleeding in the potential space between the skull periosteum* and the scalp galea aponeurosis*. * periosteum: a membrane that lines the outer surface of all bones, except at the joints of long bones * galea aponeurosis: a tough layer of dense, fibrous tissue which covers the upper part of the cranium
sulci	small fissures of the brain
Sylvian fissure	The Sylvian fissure is within the cerebrum, the largest body of the brain. The Sylvian fissure is a space filled with cerebrospinal fluid which medially separates the temporal lobe of the brain from the underlying cortical* tissue referred to as the insula and hypothalamic/diencephalic area and anteriorly from the frontal lobe. * cortical: of the cerebral cortex
syndrome	the concurrence of a number of symptoms and signs which indicate a particular diagnostic category or a particular disease process.

Synacthen	<p>a brand name for tetracosactide, a drug that is used to assess the function of the adrenal glands</p> <p>Synacthen is a synthetic product identical to the natural substance ACTH (= adreno cortico trophic hormone) used as a diagnostic tool and also in short-term treatment of a number of conditions which require the production of high levels of the natural hormone cortisol.</p>
systolic (blood pressure)	pressure in the arteries when the heart contracts and pushes the blood around the body
T	
temporal bone	either of the two irregular bones forming part of the lateral surfaces and base of the skull, and containing the organs of hearing. It is divided anatomically into four parts.
temporal horns	<p>Each lateral ventricle of the brain has an anterior (or frontal) horn and a posterior horn, and a body between the two. It also has an inferior or temporal horn (because the inferior horn goes into the temporal lobe). The temporal lobe comprises most of the lower side of each half of the cerebrum* of the brain.</p> <p>*cerebrum: See within the definition of 'cerebral'.</p>
thiamine	vitamin B ₁ . It plays a role in the activities of various enzymes involved in the utilization of carbohydrates and thus in the functioning of nerves, muscles, and the heart.
third ventricle	a space filled with cerebrospinal fluid in the midline of the brain at the level of the hypothalamus
thrombocytopenia	<p>a reduction in the number of platelets* in the blood, resulting in a tendency to bleed</p> <p>* platelets: the smallest type of blood cell</p>
thyroid hormones	<p>the three hormones produced by the thyroid gland and thyroxine and triiodothyronine, which regulate metabolism, and calcitonin, which helps to regulate calcium levels in the body.</p> <p>Calcitonin is produced by the parathyroid glands which are embedded in the thyroid gland.</p>

traumatic	<p>Trauma can vary from trivial to fatal and in the context of a head injury it can cause a minor or mild head injury.</p> <p>(PTA: post-traumatic amnesia. See the definition of post-traumatic amnesia.)</p>
T2W [as in T2W gradient echo sections]	<p>These are sequences of the magnet rotation when taking an MRI scan; they show different components of the structure/chemistry of the brain based on the amount of water content. In T2-Weighted images the fluid of the brain appears white, whilst the substance of the brain appears in shades of grey to black.</p>
U	
urea	<p>a waste product of the breakdown of proteins by the liver that is transported to the kidneys and eliminated in the urine</p>
V	
vasculature	<p>arrangement of blood vessels in the body or in an organ or body part</p>
ventricle	<p>cavity or chamber. Both the heart and brain have anatomical parts known as ventricles. The brain has four ventricles: one in each of the two cerebral hemispheres; a third at the centre of the brain, above the brainstem; and a fourth between the brainstem and cerebellum.</p> <p>The right ventricle of the brain is one of the two lateral ventricles. It lies within the cerebral hemisphere between the basal ganglia medially and white matter laterally.</p> <p>Also see the definition of lateral ventricle.</p>
vertex	<p>the top of the head</p>
W	
whiplash injury	<p>an injury to the soft tissues, ligaments, and spinal joints of the neck caused by a forcible and violent bending of the neck backwards and then forwards, or vice versa. Such injury most commonly results from sudden acceleration or deceleration.</p>

white matter	<p>whitish nerve tissue, especially of the brain and spinal cord. It is made up of myelinated axons* of neurons*.</p> <p>an axon: a nerve fibre; the long threadlike extension of a nerve cell that conducts nerve impulses from the cell body. A myelinated axon is an axon that is coated with a layered insulated and protective sheath of myelin (a white fatty material). The myelin sheath increases the efficiency of nerve impulse transmission.</p> <p>* neuron: a nerve cell, a specialized cell transmitting nerve impulses</p>
X	
Y	
Z	