Independent investigation into the death of Mr Jamal Mohamoud a prisoner at HMP Pentonville on 18 October 2016

A report by the Prisons and Probation Ombudsman
Our Vision

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

Our Values

We are:

Impartial: we do not take sides
Respectful: we are considerate and courteous
Inclusive: we value diversity
Dedicated: we are determined and focused
Fair: we are honest and act with integrity
The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jamal Mohamoud died from a stab wound on 18 October 2016 at HMP Pentonville. He was 21 years old. I offer my condolences to his family and friends.

Mr Mohamoud’s death was the tragic result of two gangs vying for control of the supply of drugs, mobile telephones and weapons on G wing in Pentonville. This is sadly emblematic of the increasing problem of violence in prisons. The struggle culminated in an altercation on 18 October between two groups of armed prisoners. During this fight, Mr Mohamoud was fatally stabbed and two other prisoners were seriously injured. Three prisoners were charged with Mr Mohamoud’s murder, but were subsequently found not guilty at trial. One of these prisoners, prisoner A, was found guilty of wounding Mr Mohamoud’s friend, Prisoner L, and was sentenced to 12 years’ imprisonment.

This investigation has examined whether there was anything the prison could have done to prevent Mr Mohamoud’s death.

Homicides are mercifully rare in prison and we readily accept that identifying those likely to carry out such killings can be difficult. We are satisfied that there was no intelligence which indicated Mr Mohamoud was directly at risk from those charged with his murder. However, it is evident that G wing had become an increasingly difficult and dangerous place to live and work, and that incidents of violence were not always properly investigated. In addition, the prison did not respond appropriately to specific intelligence received shortly before Mr Mohamoud’s death about knives being on the wing and the risks to prisoners and staff.

A further concern is that Mr Mohamoud and the three prisoners charged with his murder should not have been unlocked from their cells on the afternoon of his death. The prison needs to investigate why they were unlocked and to address the underlying reasons to prevent similar problems in future.

Staff reacted quickly and competently to bring the situation under control and treat Mr Mohamoud in what must have been frightening circumstances. However, there was a delay in requesting ambulances for the two further stab victims and a nurse’s safety was potentially compromised. The police also had difficulties obtaining the information they needed to complete their murder investigation and Pentonville did not adequately preserve all the associated evidence.
This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman

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Summary

Events

1. Mr Jamal Mohamoud was remanded into custody in November 2015, charged with offences of robbery. He was initially taken to HMP Pentonville but on 24 November, he was transferred to HMP Belmarsh. On 10 December, Mr Mohamoud was convicted and sentenced to five years and six months imprisonment.

2. On 14 January 2016, Mr Mohamoud was transferred back to Pentonville. Over the following months, he was involved in several fights and sometimes officially disciplined. These violent incidents were not always investigated but, when they were, Mr Mohamoud said they were related to gang affiliations. There were also concerns that he was involved in drug supply in the prison and had been in possession of a knife.

3. On 15 July, Mr Mohamoud was sentenced to a further six years and six months imprisonment for firearms offences. During July and August, Mr Mohamoud was involved in further fights and involved in the supply of drugs and mobiles in the prison. He was suspected of being a leader of a Somali gang on G wing.

4. On 17 October, prisoner A, a prisoner later charged with Mr Mohamoud’s murder, received a package of illicit items for another prisoner and unpacked its contents. (The packet was thought to contain drugs, mobile telephones and, potentially, weapons.) Mr Mohamoud was reportedly aggrieved by this as he wanted to control the supply of illicit items into the prison and confronted him. Several witnesses said that the prisoner threatened Mr Mohamoud with a large combat knife and threatened to kill him if he did not move cells. (Mr Mohamoud lived in a cell that was well-positioned to receive packages from drones.)

5. That afternoon, prisoner B, told an officer that he had seen large knives in a cell and was very concerned that staff and prisoners were at risk. The officer told senior staff, who arranged to search the cell the next morning. The specific information about the potential presence of knives was not passed onto the Head of Security who arranged the search. Those searching believed they were doing so because there was intelligence that prisoners were keeping hooch (illegal alcohol) in the cell. The search took place on 18 October and found hooch and drugs in the cell, but no knives.

6. Prisoner B said that on 18 October he told Supervising Officer (SO) A that prisoners were likely to fight with knives on the wing. The SO denied this conversation occurred. Around lunchtime, the prisoner told another officer that four prisoners (three of whom were later charged with Mr Mohamoud’s murder) owed another prisoner £10,000 and should not be unlocked from their cells. The officer told the SO, who was told by the head of security not to unlock these cells. After the prisoners complained, the SO decided to unlock them. Mr Mohamoud was not due to be unlocked from his cell that afternoon but he also asked an officer to unlock him and she did so because she was unfamiliar with the wing and believed Mr Mohamoud was a wing worker.
7. A short time later, at 3.09pm, a fight broke out between two rival gangs of armed prisoners. During this incident Mr Mohamoud was stabbed. Staff tried to stop the bleeding and resuscitate Mr Mohamoud but he was pronounced dead by a doctor at 4.31pm.

8. Two other prisoners, from rival gangs, were also stabbed during the fight and taken to a suite of treatment rooms on another wing. Other than those treating them, staff were unaware that there had been multiple casualties during the incident. This led to a delay in requesting an ambulance for these two other victims. Both prisoners made a full recovery after surgery.

9. The police told the prison that they would break the news of Mr Mohamoud’s death to his family. Unfortunately, by the time they managed to do so, his family had already been informed of his death by other prisoners at Pentonville.

10. Three prisoners, prisoner A, prisoner M and prisoner C, were charged with the murder of Mr Mohamoud but were found not guilty. Prisoner A was found guilty of wounding another prisoner, one of Mr Mohamoud’s friends.

11. The exact circumstances of what happened to Mr Mohamoud remain unclear. However, both from the judge’s comments at trial and information from other prisoners after Mr Mohamoud died, it seems certain that his death arose from gangs vying to control the supply of illicit items on G wing.

Findings

Managing violence and gangs

12. We found that not all violent incidents on G wing were investigated properly and that violence reduction boards were not always convened when they should have been. We also found that further work is needed to identify and manage the risk presented by, and to, prisoners who are members of gangs.

Security Information

13. Staff did not act appropriately on intelligence about the presence of knives on G wing, and about prisoners being at risk. Intelligence Reports (IRs) were not submitted and crucial information was not passed on to security staff.

Unlocking cells G2-13 and G2-14

14. The SO should not have unlocked cells G2-13 and G2-14 until a full security investigation had taken place.

Unlocking Mr Mohamoud

15. Mr Mohamoud should not have been unlocked from his cell. The officer should have first verified whether or not he was a wing worker. (He was not.)

Emergency Response

16. Staff responded bravely to a clearly frightening and distressing situation. They should be commended for their efforts to treat the victims. However, most staff were not aware that there were two further stab victims in addition to Mr
Mohamoud, and this led to a delay in requesting further ambulances. This needs to be clearly communicated in any future emergencies with multiple victims.

17. Pentonville also needs to ensure that all evidence is preserved and supplied to the police.

Recommendations

- The Governor should ensure that any incidents of violence are investigated thoroughly. In addition, gang affiliations should be recorded and investigated with explicit consideration given to the most effective way of safeguarding those involved.

- The Governor and Head of Security should ensure that all staff understand the importance of the intelligence system for the effective management of risk and are properly trained to assess and submit security intelligence.

- The Governor should commission an investigation into the highlighted decisions to unlock prisoners, addressing, in particular, the need for decisions which could impact prisoner or staff safety to be discussed and agreed with senior managers, and the need for staff to unlock prisoners in accordance with the regime. The investigation should address, in particular, the actions of SO A and consider the need for any further action under the terms of the code of discipline.

- The Governor and Head of Healthcare should ensure that when there is a serious incident involving multiple casualties, the emergency code system is used appropriately to ensure there is no delay in treatment or requesting an ambulance for any victim.

- The Governor should ensure that after a serious incident, the prison recognises the primacy of the police investigation, all evidence should be preserved, witnesses and suspects identified and separated and all information requested by the police disclosed as a matter of urgency.
The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

19. The investigator and the Assistant Ombudsman, met with the police on 24 October 2016. They agreed that the investigator could continue with parts of her investigation although this would not be completed until after the outcome of criminal proceedings. The police provided the investigator with some witness statements.

20. The investigator and the Assistant Ombudsman visited HMP Pentonville on 27 October 2016. They obtained copies of relevant extracts from Mr Mohamoud’s prison and medical records. HM Prison and Probation Service (HMPPS) also commissioned an investigation into Mr Mohamoud’s death which we have received.

21. The investigator interviewed 14 members of staff at Pentonville in March and July 2016.

22. NHS England commissioned a clinical reviewer to review Mr Mohamoud’s clinical care at the prison. The clinical reviewer attended most of the interviews with the investigator, along with his colleague.

23. We informed HM Coroner for Inner North London of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

24. Three prisoners, prisoners A, M and C were charged with Mr Mohamoud’s murder. Following a three-month trial which concluded in December 2017, they were acquitted of his murder. Prisoner A was found guilty of wounding another prisoner with intent to do grievous bodily harm, and was sentenced to twelve years imprisonment. The investigator met with the police in January 2018 to understand more about the circumstances of the prisoners’ acquittal.

25. One of the Ombudsman’s family liaison officers contacted Mr Mohamoud’s family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They did not raise any issues.

26. Mr Mohamoud’s family received a copy of the initial report. They raised one factual inaccuracy. This report has been amended accordingly.

27. HM Prison and Probation Service (HMPPS) also received a copy of the report. They pointed out some factual inaccuracies and this report has been amended accordingly. They accepted all the recommendations apart from one, which they rejected, and their action plan is attached as an annex. This rejected recommendation has been brought to the attention of the Chief Executive Officer of HMPPS, who has corresponded separately with the Prison and Probation Ombudsman.
Background Information

HMP Pentonville

28. HMP Pentonville is a local prison that holds over 1,200 young adult and adult men. The prison primarily serves the courts of north and east London.

29. Healthcare services are provided by Care UK in partnership with Enfield and Haringey Mental Health Trust. There is a large purpose-built healthcare centre which has 22 inpatient beds and a day care facility for patients with mental health problems who are managed on the wings.

HM Inspectorate of Prisons

30. The most recent inspection of HMP Pentonville was conducted in January 2017. Inspectors acknowledged that Pentonville was a challenging prison to manage and that pervasive gang behaviour challenged stability and good order. Inspectors reported that while there had been some improvements since the last inspection, levels of violence remained too high. There had been 196 assaults on staff and prisoners in the previous six months, many of which were serious. Violence had often been linked to gang affiliations and trading illicit items. They also found that measures to address violence had improved.

31. Inspectors concluded that the reporting and quality assurance of security information and use of force needed attention to ensure that poor behaviour was being identified, well managed and dealt with fairly. They noted there had been significant delays in processing security intelligence and only two-thirds of intelligence-led searches were carried out. They found that there had been some proactive measures to address levels of disorder and to limit the supply of drugs in the prison although drug availability remained high. There was a wide range of measures to interrupt supply routes. However, inspectors had significant concerns about safety in the prison. 70% of prisoners said they had felt unsafe at some time.

Independent Monitoring Board

32. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2017, the IMB reported that many improvements had been made in the last year following Mr Mohamoud’s murder and the unrelated escape of two prisoners. These included dogs being used as part of the prison’s drug and violence reduction strategy, metal detection portals, caged gates to manage prisoner movement more securely, all uniformed staff wearing body-worn cameras, CCTV being installed on the wings and perimeter walls and improved security to exercise yards to prevent illicit items being thrown over. Cell windows were also in the process of being replaced.

33. However, the IMB concluded that Pentonville still had a considerable problem with drugs. The board noted that this put staff and prisoners at risk from violence associated with unpredictable behaviour caused by reactions to drugs and bullying over debts.
Previous deaths at HMP Pentonville

34. Mr Mohamoud was the tenth prisoner to die at Pentonville since June 2014, five of these deaths had been self-inflicted. This was the first murder to occur at Pentonville since we began investigating deaths in custody in 2004.

The Mercury Intelligence System

35. The Mercury Intelligence System is a national IT system for managing and analysing intelligence in HMPPS. Mercury enables the transfer and sharing of intelligence within and between establishments, both in custody and in the community. The aim of Mercury is to maintain control and order within prisons, prevent escapes and reduce the supply of drugs and mobile phones in prisons.

36. Staff submit Intelligence Reports (IRs) which must be graded. If the member of staff assesses that the intelligence identifies that there is a clear, implied or potential threat to the security objectives of the establishment, the intelligence must be processed immediately and graded “high”. Security Management must be informed immediately, so that an appropriate response is undertaken to counteract any threat. Intelligence graded “medium” must be analysed by management within 24 hours and “low” within 72 hours.

Incentives and Earned Privileges (IEP) Scheme

37. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Assessment, Care in Custody and Teamwork (ACCT)

38. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner’s most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).
Key Events

17 November 2015 – 16 October 2016

39. On 17 November 2015, Mr Jamal Mohamoud was remanded to custody, charged with offences of robbery, and taken to HMP Pentonville. His case was committed to the Central Criminal Court. Police intelligence indicated that he was an influential member of a gang in the community.

40. On 24 November, Mr Mohamoud was transferred to HMP Belmarsh. On 10 December, Mr Mohamoud was convicted and sentenced to five years and six months imprisonment. On return to Belmarsh, he became aggressive, was restrained by staff and taken to the segregation unit. He said he would kill himself so staff started Prison Service suicide prevention procedures, known as ACCT. He said he was being persecuted by other prisoners and felt unsafe in prison. This ACCT was closed on 16 December once Mr Mohamoud was assessed as no longer being a risk to himself.

41. During December, Mr Mohamoud was involved in several assaults on staff and other prisoners and was assaulted himself. Intelligence indicated that this may have been due to gang-related conflict.

42. On 14 January 2016, Mr Mohamoud transferred back to Pentonville. He told staff that he had problems with other prisoners on A, C and D wings and he was therefore located on G wing. He was involved in fights with other prisoners in February, March and May. As a result, he was sometimes segregated or his Incentives and Earned Privilege (IEP) level was reduced to basic. These instances of violence were not always investigated. When they were, Mr Mohamoud indicated that the fights were motivated by postcode loyalties in the community. He said that incidents would continue to happen if he had contact with his rivals. In April, there was intelligence to suggest that Mr Mohamoud was connected to drug supply in the prison. On 7 June, Mr Mohamoud pleaded guilty to a firearms offence at Wood Green Crown Court.

43. On 14 June, Mr Mohamoud moved from another cell on G wing to cell three on the fifth landing. This was one of the cells best placed to receive illicit items from drones. On 15 June, Mr Mohamoud, along with another prisoner, was searched due to intelligence received that he might have been in possession of a knife used to assault another prisoner. No knife was found. On 15 July, Mr Mohamoud was sentenced to a further six years and six months imprisonment which was to run consecutively with his current sentence.

44. On 21 July, an anonymous note was found by staff stating that Mr Mohamoud and his cellmate would die if they were not moved off the wing. An IR was submitted. There is no evidence that any investigation took place.

45. On 23 July, an IR was submitted suggesting that Mr Mohamoud had received a large quantity of mobile phones and drugs via a drone and that he was the leader of a Somali gang on the wing. No evidence of any further action being taken was given to the investigator. On 28 July, Mr Mohamoud’s IEP level was again reduced to basic for two weeks following a fight with another prisoner. During August, he was again seen fighting with other prisoners and, on 16 August, staff
found mobiles and chargers during a search of Mr Mohamoud’s cell. His IEP level was reduced to basic. He progressed back to standard on 5 September.

46. On 17 September, an IR was submitted that Mr Mohamoud, along with other prisoners, was distributing illicit items especially during exercise. On the same day, another prisoner spoke to an officer stating that Somali gang members were forcing him to hand over all his tobacco and canteen due to a perceived debt he owed them. The prisoner’s mother had also transferred money to an account as requested by the gang members via text message from an illicit mobile phone. The prisoner said that the day before, Mr Mohamoud had been fighting with him over the perceived debt and the prisoner’s mother then transferred £100 the same evening. The prisoner was moved from the wing and no further investigation took place, nor did any searches occur. No IRs were submitted in relation to Mr Mohamoud. A cell search found a mobile in Mr Mohamoud’s cell on 29 September.

47. Supervising Officer (SO) A told the investigator that both she and the custodial manager, had concerns that Mr Mohamoud was part of a group of Somalis living on G wing who needed to be split up. She said that she was not aware of any specific events which led her to believe this, but that from her experience of working in prison she knew that he was a negative influence on the wing. She said she attempted to move him on one occasion when he had left the wing for a disciplinary hearing. She found a space for him on another wing and asked that he be taken straight there after the hearing. However, he returned to G wing as staff had concerns that he might not be safe on other wings due to gang-related conflict.

48. The prisoner who lived next door to Mr Mohamoud, told the police that, around 10 October, Mr Mohamoud received a parcel which had been thrown over the prison wall. He said this contained several mobile telephones, cannabis and a knife. Mr Mohamoud asked him to look after the telephones and drugs. He said that there was tension between Mr Mohamoud and prisoner C, another prisoner who was later acquitted of Mr Mohamoud’s murder, because prisoner C believed he was entitled to something from this parcel.

17 October

49. On 17 October, a contractor alerted prison staff to say that he had seen a package enter the prison by the cells at the end of G wing. CCTV showed a line being thrown over the prison wall, a package attached and pulled into a cell on the top floor at the end of G wing. The cell identified was searched the same day by security staff but nothing was found. No further action was taken.

50. During the trial, prisoner A said he had received this package for another prisoner and unpacked its contents. Evidence heard during the trial indicated that when Mr Mohamoud and some of his associates learned of this, they were aggrieved and confronted members of a rival gang, including prisoner A. Several witnesses said that he threatened Mr Mohamoud with a large combat knife and said he would kill him if he did not move cells. Prisoner A denied doing so.

51. At 3.30pm, prisoner B spoke to Officer A. The officer said that prisoner B looked worried and told him that he had seen knives which were 20cm long in cell G5-01
that morning. He said he had never seen anything like them during his time in prison and was worried about staff or prisoners being killed. The officer said prisoner B seemed extremely concerned; he was a trusted prisoner who was usually a reliable source of information. He told the officer that there had been two prisoners in the cell, prisoners E and F, but they did not live in the cell, which was occupied by two other prisoners, G and H.

52. Officer A radioed the head of security, asking her to contact him. He did not receive a response so contacted the communications room and was told she was in the chapel. The officer went to the chapel and to the head of security’s office but could not locate her. He radioed a request for her to contact him. (The head of security was not in the prison that afternoon.) The officer spoke to the head of operations, and Senior Officer (SO) B who were nearby. He told them what prisoner B had said and gave them the names of all four prisoners. The officer told the investigator he told them he thought they needed to deal with it and not to leave it. He said he returned to the wing to conduct his duties. The officer said he expected there to be a lock-down search of the wing that day. The officer said he did not submit an IR with the information as he was too busy for the rest of his shift.

53. The head of operations told the HMPPS investigator that he had asked Officer A if he intended to submit an IR and was told that he did. He was aware that prisoner G and prisoner H had previously been found in possession of hooch (illegal alcohol). The head of operations told the deputy governor, that they needed to search cell G5-01 and move the two prisoners who lived there. It was around 5pm and they agreed it was too late to conduct a search that day but would do so the following morning.

54. SO B told the HMPPS investigator that as the information from Officer A was from only one prisoner it was classed as an unverified single strand. The deputy governor said that the information from Officer A was also limited as they did not know the current location of the knives. He telephoned the head of security at home to ask her to organise the search the next morning. He also instructed that prisoner F should be moved to the segregation unit, along with prisoner I, due to concerns that they were smuggling contraband into the prison.

55. The head of security told the investigator that when the deputy governor telephoned her, he had asked her to arrange a search of G5-01 the next morning due to a concern that prisoners had hooch in their cell. She said he did not mention intelligence about knives being in the cell.

56. Mr Mohamoud’s partner told the police that he telephoned her at 11.25pm and they spoke for 90 minutes. (This telephone call is likely to have taken place on an illicit mobile telephone as there is no record of it on the prison telephone system.) Mr Mohamoud told her he was angry about a parcel which had come into the prison. He said he had confronted the other prisoner, they had argued and that he had been threatened with a very large knife. Mr Mohamoud told his partner that he had arranged for another prisoner to steal this parcel which contained sim cards, mobile telephones and a knife.
18 October

57. On 18 October, at 7.30am, the head of security briefed security staff to search cell G5-01 on the basis that they had received intelligence that the prisoners might have hooch in the cell. She did not mention searching for knives, as she said she was unaware of this information, but she said that she expected this search to be thorough and therefore to have found any knives if any had been there. SO B was present at this briefing but could not remember whether he mentioned the possibility of knives in cell G5-01.

58. Staff searched cell G5-01 at 7.45am. Hooch and suspected drugs were found and the occupants, prisoner G and prisoner H, were relocated. Officer A said he was surprised no other cells on G wing were searched but assumed security staff were aware of the intelligence he had provided. The head of security chaired the morning managerial meeting on 18 October. The potential presence of knives on G wing was not discussed.

59. Prisoner B subsequently told the police that Mr Mohamoud had confronted his rivals that morning and said: “If you want war, we will give you war.” He told the HMPPS investigator that he had told SO A he believed two rival gangs were going to fight on the wing with knives. He said that the SO told him she would see what she could do. The SO told the investigator that this conversation did not take place.

60. Mr Mohamoud’s partner told the police that he rang her at 11.36am. (Again, this call is likely to have taken place on an illicit mobile telephone.) Mr Mohamoud said he felt violated after being threatened with a knife and his partner told him to let the matter drop. He said he did not intend to do so and he was going to get someone to let him out of his cell that afternoon as he had already had his association that morning.

61. Around 12.00pm, Officer A was completing the roll check. When he got to prisoner J and prisoner C’s cell, he found prisoner J was standing in front of the observation panel. He moved away when asked but prisoner C could be seen lying in a strange position by the sink. He asked Officer B to submit an IR. The officer said that he did not remember this information or being asked to submit an intelligence report.

62. Around the same time, prisoner B told Officer B that the prisoners in cells G2-13 and G2-14 – prisoners A, M, C and J - owed another prisoner, prisoner I, £10,000. The officer assumed this was connected to the supply of drugs and mobile telephones in the prison. Prisoner B told the officer not to let the four prisoners out of their cells during association that afternoon or they would get hurt. The officer said prisoner B seemed genuinely concerned and he believed the intelligence that prisoner B had provided was reliable. The officer also said that in the two years he had worked at the prison he had never had a prisoner tell him such specific information.

63. Around 12.30pm, Officer B told Officer A that prisoner B had told him not to unlock cells G2-13 and G2-14. Officer A said his shift was soon ending but he told Officer B to make sure he told everyone and make sure he submitted an IR. After he had served lunch on G wing (during which time the prisoners were
locked in their cells) Officer B passed this information on to SO A. She said she would deal with it after the lunch break. The SO telephoned the head of security who instructed her not to unlock those two cells for association. Staff did not submit an IR.

64. Around 2.10pm officers opened the cells on the first, second and third landings for association. The cells on the fourth and fifth landings were not unlocked as they had already had association that morning. Cells G2-13 and G2-14 were also not unlocked and these prisoners rang their cell bells as they had expected to be let out of their cells. SO A answered the cell bells and they asked why they had not been unlocked. The SO said that she explained that staff were concerned that they might be at risk from other prisoners. The prisoners denied this and asked to be unlocked, assuring the SO that there would not be any trouble. The SO asked the officer to contact head of security for advice. The officer telephoned the head of security’s office but there was no answer and he informed the SO. The SO could not remember asking Officer B to contact the head of security but said she also tried, unsuccessfully, to contact her herself. The SO decided that, particularly as prisoner I had not been unlocked for association, it would be safe to unlock the other four prisoners, and she did so.

65. Officer C was working on G wing that afternoon on the fifth landing. She did not normally work on G wing and this was only the second time she had done so. The officer said that prisoner K, asked if she would unlock Mr Mohamoud. She went to Mr Mohamoud’s cell, whose cell bell was ringing. He asked her if he could be unlocked from his cell. She noted that he was wearing green trousers which signified that he was a wing worker so she unlocked him. Prisoner K denied asking the officer to unlock Mr Mohamoud. Mr Mohamoud was not a wing worker and so should not have been unlocked. Another prisoner later said that they had given Mr Mohamoud green trousers.

66. Around 3.00pm, SO A came out of the wing office and noticed that the wing seemed more “lively” than usual. Prisoner C walked past her purposefully and she asked him into the wing office. She spoke to him, explaining that she did not want there to be any trouble. He assured her that there would not be.

67. CCTV shows Mr Mohamoud speaking to prisoner A on the second landing. Shortly after this, prisoners A, C and M went upstairs. (There was no CCTV on the upper landings of G wing at the time.) Later, at trial, the judge indicated that, on the balance of the evidence, both prisoners C and A were armed with knives at the time. In prisoner A’s case, it is assumed that this was one of the large combat knives seen by prisoner B the day before.

68. The police took numerous witness statements from prisoners about the events which followed. We did not interview these prisoners. According to these statements, there was a fight between two rival gangs of prisoners with Mr Mohamoud and prisoner L in one gang and prisoners A, C and M in the other. Both gangs were armed. Some witnesses said they saw prisoner A stab Mr Mohamoud and prisoner L using a combat knife. Prisoner B said that after this, prisoner A threw his knife to prisoner J who headed downstairs to the ground floor. Another prisoner said that they heard prisoner A shouting, “I told you not to fuck with me.”
69. Staff describe Mr Mohamoud then either falling or being thrown down a flight of stairs from the fifth landing to the fourth landing. Mr Mohamoud was losing a large amount of blood and officers thought he was already dead. This was 3.09pm. Staff sounded a general alarm, requested all available staff attend the wing and radioed a code red emergency followed by a code blue. (A code red indicates a medical emergency in circumstances where there is significant blood loss. A code blue indicates a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically.) Control room staff immediately requested an ambulance.

70. As Mr Mohamoud had landed on his front, staff turned him over to treat him. Staff and prisoners said that prisoner A then came from the landing above and stamped repeatedly on Mr Mohamoud’s head. Staff tried to restrain him who resisted and assaulted staff. Two prisoners assisted and managed to move him away from Mr Mohamoud.

71. While this was happening, Officers D and B went up to the fifth landing where prisoners continued fighting. Prisoner M ran away from Officer D. The officer stopped him and was about to search him when he saw four prisoners running towards them with weapons; the foremost prisoner had a table leg. He shouted for them to stop and drop their weapons but they did not do so. He stood in front of prisoner M and managed to disarm one of the prisoners and restrain him. The other three prisoners continued to try to get past Officer D to reach prisoner M. Further staff attended and restrained these prisoners.

72. The deputy Head of Healthcare, immediately went to G wing when he heard the code red. He estimated that it took him less than three minutes to get there. When he arrived, Officer E was applying pressure to Mr Mohamoud’s chest wound. The deputy head of healthcare said that Mr Mohamoud had a large deep wound to his chest with his ribs exposed. Nurses A and B, who arrived a few seconds later, confirmed there were no signs of life. The deputy head of healthcare inserted an airway. Nurse B took over from the officer and applied a trauma dressing to Mr Mohamoud’s wound. They began chest compressions, administered oxygen using a facemask and attached a defibrillator to Mr Mohamoud. This advised not to shock him. At 3.17pm, at the deputy head of healthcare request, control room staff requested an air ambulance. The paramedics arrived at 3.29pm and took over Mr Mohamoud’s care.

73. Meanwhile, Nurses, C and D had been on their way to assist with Mr Mohamoud’s treatment when prisoner L came towards them being supported by an officer and a prisoner. He had also been stabbed. Nurse D continued onto G wing while Nurse C took prisoner L to the suite of treatment rooms on C wing. When unlocking the gate to C wing, she realised the officer was no longer accompanying her. She did not lock the gate behind her as she was concerned about her own safety being left on her own with a prisoner.

74. Nurse C assessed and treated prisoner L’s stab wounds. Prisoner L was worried he was going to die and the nurse reassured him. She ran outside the room and shouted to an officer that she was treating someone and needed assistance.
Nurse E arrived within two minutes. Nurse C said that although prisoner L’s wounds were unlikely to be life-threatening, they needed emergency treatment.

75. Officer F then brought prisoner C, who had also been stabbed, into the suite of treatment rooms and they went into one of the vacant rooms. Nurse C left prisoner L with Nurse E and went to the centre of the prison to speak to the custodial manager, informing him that there were two prisoners in the treatment room with stab wounds who needed hospital treatment. At 3.25pm, radio traffic indicates that two further ambulances were requested. Nurse C returned to the treatment room. Around ten minutes later she returned to the centre of the prison to check the ambulance had been requested. By this time, more nurses had come to the treatment room and assisted in treating the two prisoners.

76. Nurse F took over the care of prisoner C. She did regular checks of his blood pressure, which was normal. His demeanour then changed and he said he did not “feel right”. His heart rate was elevated. The nurse again asked after the ambulances. He continued to deteriorate and the nurse gave him oxygen. Prisoner L also became agitated. The first ambulance arrived around 3.45pm. When the first ambulance arrived, the paramedics treated both patients until the second ambulance arrived at 4.00pm and both prisoners were taken to hospital. Both men required surgery for their injuries but made a full recovery.

77. The Helicopter Emergency Medical Service (HEMS) doctor and paramedic had arrived at 3.35pm. They moved Mr Mohamoud to the second landing so that they had more space. They opened Mr Mohamoud’s chest and sutured the heart wound. This proved unsuccessful and Mr Mohamoud was pronounced dead at 4.31pm by the HEMS doctor.

78. In order to clear the landings quickly and try to contain the crime scene, staff had locked prisoners into the closest and most convenient cells available, which were not necessarily their own. As a result, it took several hours to locate prisoner A. Around 7.30pm, a team was briefed, entered cell G3-15, restrained him and took him to the segregation unit. He was later arrested by the police. A large combat knife was found in an open cell on the ground floor. A lock knife and two improvised weapons were also found.

79. G wing was on lockdown for the next few days, meaning that prisoners were not allowed to leave the wing. A search of the entire wing took place, along with the rest of the prison. Four improvised weapons were found, as were 13 mobile phones, various illicit substances, phone chargers, sim cards, cash and hooch. 34 prisoners were moved to other prisons within 24 hours.

Contact with Mr Mohamoud’s family

80. At 4.00pm, two members of staff were appointed as family liaison officers. The police told the prison that they should not contact the family, and that the police themselves would break the news and liaise with Mr Mohamoud’s family. The prison passed on the appropriate information to the police about the prison’s contribution to funeral expenses and returning Mr Mohamoud’s property. Unfortunately, Mr Mohamoud’s partner found out that Mr Mohamoud had died from other prisoners and from his brother before the police had the opportunity to break the news.
Support for prisoners and staff

81. After Mr Mohamoud’s death, the Deputy Director of Custody, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team and a staff trauma team also offered support. They also offered group and individual trauma counselling.

82. The prison posted notices informing other prisoners of Mr Mohamoud’s death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Mohamoud’s death. Other prisoners who had been significantly affected by Mr Mohamoud’s death were also assessed and suicide and self-harm measures opened where these were deemed necessary.

Prisoner A, Prisoner M and Prisoner C

83. Prisoner A had been detained in an Immigration Removal Centre (IRC) after the expiry of his prison sentence in 2015. His behaviour in IRCs was challenging and he was held in three different centres. Intelligence from the Home Office indicates that he was involved in gang culture and drug supply; he assaulted a member of staff and assaulted another detainee when armed with a knife. On 23 March 2016, he was returned to Pentonville due to his aggressive behaviour towards others. He was prescribed antipsychotic medication, and a doctor and nurse consistently assessed his mental state as stable and recorded that he did not present a risk of harm to himself or others.

84. Prisoner M had been recalled to custody for breaching his licence in 2014. He had originally been sentenced for firearm offences. Prisoner C had been recalled to custody for breaching his licence in April 2016. He had originally been sentenced for drug and robbery offences.

85. Prisoners A, M and C were charged with Mr Mohamoud’s murder but were found not guilty at the end of a three-month trial in December 2017. A note on the acquittals provided by prosecution lawyers indicated that factors relevant to this verdict were: the lack of CCTV of the murder, unreliable evidence given by prisoner witnesses, one key anonymous witness withdrawing from giving evidence due to their identity being revealed, Mr Mohamoud’s involvement in gang activities himself, prisoner C suffering serious injuries himself, the general lack of security in the prison and the failure of the prison to keep a clear record of events after the incident.

86. All three prisoners were also charged with wounding with intent to cause grievous bodily harm, the victim of this offence being prisoner L. Prisoner A was found guilty of this offence and was sentenced to twelve years imprisonment. Prisoners M and C were found not guilty. In sentencing prisoner, A, the Judge indicated that he was satisfied that he had a large combat knife which he threatened Mr Mohamoud with on 17 October and used to stab prisoner L on 18 October.
Information after the incident

87. Prisoners indicated that Mr Mohamoud was in a rival gang to the individuals who were acquitted of his murder. These individuals wanted the cells which Mr Mohamoud and his friends occupied as these were closest to where drones dropped off illicit packages in the evening.

88. IRSs submitted after Mr Mohamoud’s death indicated that other prisoners used his cell to receive parcels from outside the prison. Mr Mohamoud believed he should be entitled to a share of these parcels, whereas others disagreed. IRSs also indicated that Mr Mohamoud had found out that prisoner C was in possession of £5,000 worth of illicit psychoactive drugs (NPS). He had allegedly tried to take some of this on 17 October but was unsuccessful and prisoners alleged Mr Mohamoud was attacked in revenge. Other IRSs indicated that the attack was because of rivalry between two gangs and had been ordered by the unnamed leader of one of the gangs and was in retaliation for an attack which had taken place a few days earlier.

Post-mortem report

89. The post mortem report concluded the cause of Mr Mohamoud’s death was an incised wound to the chest. The report made no reference to any head injury or blunt force trauma.
Findings

Managing violence and gangs

90. In a Learning Lessons Bulletin we published in 2016 into homicides in prison, we concluded that all allegations of violence, bullying or intimidation should be taken seriously and investigated appropriately. Suspected perpetrators should be monitored and challenged through effective interventions, and potential victims supported as part of a robust violence reduction strategy.

91. Mr Mohamoud was involved in several fights with other prisoners at Pentonville. However, none of these involved the prisoners who were charged with his murder and there was no intelligence to suggest that Mr Mohamoud was specifically at risk from these three prisoners. While we recognise that these three prisoners were acquitted of his murder, there seems little doubt that they were involved in some way in the altercation that led to Mr Mohamoud’s death.

92. The head of safer prisons, said that after any violent incident there should be a violence reduction investigation examining the reason for the incident and to elicit learning from it. Not all the incidents Mr Mohamoud was involved in were investigated. When they were, Mr Mohamoud indicated that the violence had occurred due to gang affiliations from outside the prison and that it would continue to happen when he had contact with his rivals.

93. The head of safer prisons told the investigator that if a prisoner is repeatedly involved in violent incidents, he must attend a violence reduction board. This is a multi-disciplinary board aimed at examining relevant issues and preventing further violence. He said that this should occur after three incidents of violence, if not earlier. Mr Mohamoud had met this threshold by March 2016. The violence reduction co-ordinator, said she had tried to see Mr Mohamoud in July to arrange a board but he was on a social visit at the time. No further efforts were made despite Mr Mohamoud being involved in fights. It is regrettable that such an opportunity was not taken. None of the prisoners charged with Mr Mohamoud’s murder had ever been identified as requiring a violence reduction board.

94. The prison should have done more to keep Mr Mohamoud safe. While he was involved in many fights, without proper investigation it is not clear who was the protagonist in many of these cases or the extent to which Mr Mohamoud was the aggressor or the victim. There was also an anonymous threat made against his life in July. We consider that Pentonville should have considered more carefully the risks to Mr Mohamoud in being involved in gang affiliations, particularly as he was located in a highly sought-after cell on G wing.

95. Staff were aware that Mr Mohamoud was potentially the leader of a gang on G wing and some staff said they made efforts to get him moved from the wing. The head of security told us that moving him either within the prison or to another prison would not necessarily have solved the issue. This might have put him or others at risk and such decisions had to be carefully evaluated. Gangs were constantly forming and changing at Pentonville and, in her experience, it was often easier to manage a prisoner’s risk to himself and others on his current wing. There is, however, no evidence that the pros and cons of moving Mr Mohamoud were ever formally considered.
96. Pentonville’s *violence reduction policy*, published in July 2015 indicates that, “more work needs to be done on gangs and how prisoners involved in gangs should be managed. There should be education and training for staff on gangs, and interventions for prisoners to attend on gangs.”

97. The head of security said that she holds regular intelligence meetings with residential managers. These meetings are not minuted but the ten prisoners who managers are most concerned about are recorded. The record of the meeting for the period 1 October to 17 October indicates that Mr Mohamoud was on the waiting list to be transferred to another prison. There is no detail as to why. Mr Mohamoud was also listed as one of the prisoners to “look at” that week.

98. It is clear both from our own investigation and the judge’s comments that although three prisoners were acquitted of his murder, Mr Mohamoud’s death was related to gang rivalries and the distribution of illicit items in the prison. Pentonville needs to assure itself that it is dealing with these complex and ever-changing issues as effectively as possible. We therefore make the following recommendation:

**The Governor should review Pentonville’s violence reduction policy to ensure that any incidents of violence are investigated thoroughly. In addition, gang affiliations should be recorded and investigated with explicit consideration given to the most effective way of safeguarding those involved.**

Security information

99. In our Learning Lessons Bulletin on homicides, we concluded that prisons should have an effective security and searching strategy, which reflects the specific risks of the prisoners housed there, and enables weapons to be found and removed and, where appropriate, their owners charged or disciplined.

100. Staff received intelligence on 17 October and 18 October that there were knives on G wing, that prisoners and staff were at risk and that four prisoners owed another prisoner £10,000 and should not be unlocked. None of this information was submitted in IRs. The staff involved said that they were either too busy or had forgotten to do so. Both officers involved did immediately report the information to their managers.

101. Officer A said he was surprised only one cell on G wing was searched because of the information he passed on about knives being on the wing but he assumed that security staff were aware of the intelligence he had provided. The head of security said the officer should have immediately submitted an intelligence report about this information and graded it as ‘high’. Her security team would have assessed the information immediately, telephoned her at home and arranged a search that evening. The orderly officer and duty governor in the prison would also have been informed.

102. The head of security said that if the intelligence from both days had been submitted on an IR, a security officer would have analysed it and completed a report to determine the risk to the wing. The head of security would then have reviewed this and decided on any action which needed to be taken. She also
said she was only told about the potential presence of hooch in a cell. She said she was unaware that a prisoner said he had seen knives. This information was also not passed on to those present at the morning management meeting on 18 October, to other officers or the SO working on G wing that day or to staff who searched the cell where the knives had been seen. This was despite a member of staff (SO B) being present who was aware of the original intelligence.

103. The head of security said that if she had known about this information, she would have briefed her staff fully and ensured they were wearing personal protective equipment before they searched the cell. She would have had the cell occupants moved to the segregation unit for a full search, restricted movement on the wing and searched the cells of the other two prisoners who had been seen in the cell. She said this would have all occurred on 17 October. We make the following recommendation:

The Governor and Head of Security should ensure that all staff understand the importance of the intelligence system for the effective management of risk and are properly trained to assess and submit security intelligence.

Unlocking prisoners

Cells G2-13 and G2-14

104. Due to intelligence received that prisoners A, M, C and J were at risk from others, the head of security told SO A not to unlock them in the afternoon of 18 October. The SO said that as these prisoners were keen to come out of their cells and assured her that they were not under threat, she thought it was safe to unlock their cells. She said she was also aware that the prisoner they were thought to be at risk from was not due to be unlocked that afternoon. In fact, after the assault on Mr Mohamoud, the SO saw this prisoner out of his cell.

105. The head of security said that these prisoners should not have been unlocked until a full investigation had taken place. This would have involved herself speaking to the prisoners to assess the risk involved. She also said that if SO A was considering going against her advice, she would have expected her to consult her first. Although three of these prisoners were acquitted of Mr Mohamoud’s murder, they were involved in the dispute which took place and we therefore regard the decision to unlock them as significant.

Mr Mohamoud

106. Mr Mohamoud should not have been unlocked for association on the afternoon of 18 October. Although he had already had his association period that morning, he asked Officer C to let him out. Being unfamiliar with the prisoners on that wing, and seeing he was wearing green trousers - signifying he was a wing worker - she unlocked his cell.

107. The head of security said she would have expected Officer C to check with another member of staff if she was unsure whether Mr Mohamoud was a wing worker. Officer B said prisoners often acquired green trousers from other prisoners so they could be let out for association. During the investigation, staff said that it was not uncommon for prisoners to be unlocked when they should not have been. For example, prisoner I was seen out of his cell on the afternoon of
18 October when he should not have been. Since Mr Mohamoud’s death, a list of wing workers is placed in each landing officer’s pigeon hole. However, this does not assist those deployed to work from other landings.

108. The decision to unlock prisoners A, C and M and the separate decision to unlock Mr Mohamoud were fundamental to the tragic events which followed. The first of these decisions involved SO A disregarding the advice of a senior manager, while the second was a result of inexperienced staff being deployed to different areas in the prison and inadequate systems to counteract the effects of this staff movement. Pentonville needs to ensure they have safeguards and systems in place to ensure security in the prison is not compromised in this way in future. We make the following recommendation:

The Governor should commission an investigation into the highlighted decisions to unlock prisoners, addressing, in particular, the need for decisions which could impact prisoner or staff safety to be discussed and agreed with senior managers, and the need for staff to unlock prisoners in accordance with the regime. The investigation should address, in particular, the actions of SO A and consider the need for any further action under the terms of the code of discipline.

Emergency response

109. The clinical reviewer concluded that the attempted resuscitation of Mr Mohamoud was satisfactory. We note that this happened in an extremely distressing, chaotic, frightening situation. Staff should be commended for the bravery they showed in trying to save Mr Mohamoud’s life when prisoners were still fighting, and for bringing the situation under control.

110. Staff reacted calmly and competently, using the appropriate codes to summon assistance for Mr Mohamoud. However, most staff were unaware that there were two further victims. The officer who had accompanied the first of these prisoners, prisoner L, and a nurse to the treatment room then left the nurse alone with the prisoner and did not request further assistance. This was not in accordance with policy to safeguard healthcare staff. Another prisoner, prisoner C, then arrived with an officer. The two prisoners were from opposing gangs but were treated in the same suite of rooms. Staff were unaware of this at the time.

111. No further code red was called for these two prisoners. This was because staff had not wanted to confuse the radio traffic or divert staff resources from treating Mr Mohamoud, the most seriously injured. This meant that there was a delay in requesting further ambulances and the seriousness of the other two victims’ injuries was not communicated to the 999 controller. It also meant that further healthcare staff were not initially deployed to assist the nurses treating these two prisoners. During the subsequent debrief, staff agreed that multiple emergency codes should have been called. We make the following recommendation:

The Governor and Head of Healthcare should ensure that when there is a serious incident involving multiple casualties the emergency code system is used appropriately to ensure there is no delay in treatment or requesting an ambulance for any victim.
112. In our Learning Lessons Bulletin on homicides we concluded that following a serious assault or death, all relevant evidence should be preserved and all prisoners who were potentially involved in the incident, either as suspects or direct witnesses, should be identified quickly and held separately until the police arrived. Some staff said that the management of the prisoners and regime after the incident was chaotic. One of the suspects in this case, prisoner A, was not located until several hours after the assault. The other two suspects were identified after this.

113. The police also had serious concerns about the way the crime scene was contained following the incident and the potential contamination of evidence that occurred. Police said that staff did not preserve evidence in accordance with guidelines and, at one point, lost an improvised weapon used in the fight, which was subsequently found in a staff room. In addition, the police had significant difficulties obtaining all the information they required from the prison and, at points, relied on our own investigator to obtain this information. We make the following recommendation:

The Governor should ensure that after a serious incident, the prison recognises the primacy of the police investigation, all evidence should be preserved, witnesses and suspects identified and separated and all information requested by the police disclosed as a matter of urgency.

Clinical care

114. Mr Mohamoud had no physical or mental health issues and the clinical reviewer concluded that his clinical care was equivalent to that which he could have expected to receive in the community.

Improvements since Mr Mohamoud’s death

115. It is important to reflect the improvements that have been made at Pentonville since Mr Mohamoud’s death. Pentonville installed metal detectors at the entrance to each wing and at exit points, such as onto the exercise yard. The prison has started replacing all its windows, which now have a thin metal mesh over them making it difficult for prisoners to bring illicit items into the prison by these means. Pentonville has also replaced the netting over the prison with stronger netting, invested in anti-drone technology and has begun installing CCTV throughout the prison’s residential areas and around the perimeter wall. The progress of these improvements has been slower than anticipated due to budgetary issues and the recent collapse of Carillion, which was contracted to replace the windows and install the CCTV. Officers with dogs now constantly patrol the perimeter wall inside the prison. The number of staff on G wing has also been increased.

116. Pentonville has developed a peer mediator scheme to assist with resolving low level disputes between prisoners. HMIP noted that this was unique to Pentonville and evidence of a creative, proactive approach. The prison has also commissioned an external company, Catch 22, to assist in identifying gang allegiances, managing them and assisting prisoners to move away from gangs.
117. The head of security also said that residential managers had agreed to regularly rotate those prisoners located in cells that were best placed to get illicit items into the prison on at least a weekly basis. This was to try to minimise both the quantities of such items entering the prison and the associated bullying.