Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alexander Cusworth a prisoner at HMP Dartmoor on 26 November 2015

A report by the Prisons and Probation Ombudsman
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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*

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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 Alexander Cusworth was killed in the kitchen at HMP Dartmoor on 26 November 2015. He was 37 years old. I offer my condolences to Mr Cusworth's family and friends. In May 2016, Prisoner X, who worked in the kitchen with Mr Cusworth, was convicted of his murder.

Homicides in prison are rare. While Prisoner X had a long history of violent behaviour in prison, his recent history did not suggest he posed a danger to other prisoners, and there was no intelligence that he posed a particular risk to Mr Cusworth. His actions appeared sudden and unexpected. Despite this, I am concerned that the security process did not identify the risk he posed to others, particularly as the kitchen was a high risk area with access to high risk equipment. I also found the level of supervision in the kitchen was inadequate.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. On 21 February 2015, Mr Alexander Cusworth was remanded to HMP Exeter, charged with wounding with intent to cause grievous bodily harm. On 15 May, he was sentenced to eight years in prison and was transferred to HMP Dartmoor later that month.

2. On 5 September, Mr Cusworth started working in the prison kitchen.

3. Prisoner X had been in custody since 1996. He was convicted of murder and received a life sentence, with a minimum tariff of 15 years. While he had a history of violence in prison and in the community, his last recorded incident of violence in prison was in 2008 and he had last been found with handmade weapons in 2011. He spent a number of years in different prisons but the Parole Board never directed his release. He was transferred to Dartmoor on 9 September 2015 having previously served time there in 2013 when he had worked in the kitchen.

4. In September 2015, Prisoner X applied to work in the prison kitchen again. Staff checked his security record as part of the risk assessment process for employment. They found no evidence of violent or poor behaviour in the preceding 12 months. An employment board reviewed his application for work and, with input from the security department, decided his risk was sufficiently low to work in the kitchen. He started work there the next day.

5. On the afternoon of 26 November, Mr Cusworth and Prisoner X began their shift in different areas of the kitchen. Mr Cusworth was peeling eggs with two other prisoners. Prisoner X was preparing vegetables with two other prisoners, which required the use of a knife. Staff on duty were attending a meeting in the kitchen and were not supervising prisoners.

6. At about 3.05pm, Prisoner X walked up behind Mr Cusworth and unexpectedly stabbed him in the back with a kitchen knife. The two prisoners working with Mr Cusworth sought help from the kitchen staff, and healthcare staff tried to resuscitate him. Mr Cusworth was taken to hospital but sadly died of his injury at 4.48pm. Prisoner X was convicted of Mr Cusworth's murder on 19 May 2016.

Findings

7. There was insufficient evidence to conclude why Prisoner X attacked Mr Cusworth in the kitchen. There was no intelligence to indicate that Mr Cusworth was at risk in the days before his death.

8. Dartmoor's local policy on assessing prisoners' security risk required the security department to consider entries in the previous 12 months about violence, poor behaviour or attempts to escape. Dartmoor failed to provide evidence to confirm exactly what documents they had reviewed when they assessed Prisoner X's security risk for working in the kitchen.

9. Prisoner X had been convicted of murder, had a long history of violence, had assaulted a number of other prisoners with weapons over a number of years. Yet, his behaviour had improved and there were no records about him behaving violently or trying to escape in his security records in the 12 months preceding his risk assessment. He had last attacked another prisoner in 2008 and had last been found with a weapon in 2011. The security department would therefore not have identified these historic incidents as part of their standard risk assessment process.

10. Despite Prisoner X having worked in the kitchen at Dartmoor in 2013 without incident, he had stabbed a cellmate in a previous prison and had admitted assault of another prisoner at Dartmoor in 2013. Neither of these incidents were taken into account in assessing or reviewing his suitability to work in the kitchen in 2013 or 2015. The assessment of his security risk should have considered all his risk factors, particularly his history of violence against other prisoners and his use of weapons.

11. Prisoners are not closely supervised by staff when they work in the kitchen which is a high risk environment, with potential access to bladed equipment. While kitchen staff might not have prevented Prisoner X's actions on the day as it was sudden, prisoners, including those at medium risk of harm to others, were left unsupervised, with access to high risk equipment.

Recommendations

- **The Governor and Head of Security should ensure that the security process takes into account all relevant factors about a prisoner's security risk when they are assessed for a job and that they record the reasons for their decision.**

- **The Governor should ensure that prisoners are adequately supervised in high risk work areas.**

The Investigation Process

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

13. The investigator visited Dartmoor and obtained copies of relevant extracts from Mr Cusworth's prison and medical records. We suspended our investigation at the request of the police and the Crown Prosecution Service and resumed in June 2016 after the conclusion of Prisoner X's trial. We had to suspend our investigation again in September 2016 because of a delay in obtaining the clinical review, but resumed in January 2017. We regret the consequent delay in issuing this report.

14. Another investigator took over the investigation, and interviewed 10 members of staff and two prisoners at Dartmoor. Prisoner X declined to be interviewed. The investigator obtained copies of police witness statements for staff and prisoners.

15. NHS England commissioned a clinical reviewer to review Mr Cusworth's clinical care at Dartmoor. He also had access to Prisoner X's medical records.

16. We informed HM Coroner for Exeter and Greater Devon of the investigation. We have given the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Cusworth's parents, to explain the investigation. They wanted to know why no prison staff were present in the kitchen supervising at the time of the incident, whether the view of the food preparation area from the kitchen office was obscured and why there was no CCTV in the kitchen area. They wanted details of the medical care Mr Cusworth received, which is addressed in the clinical reviewer's report. Mr Cusworth's parents received a copy of the initial report. The solicitor representing Mr Cusworth's parents wrote to us pointing out some factual inaccuracies and the report has been amended accordingly. The solicitor also made some observations on behalf of Mr Cusworth's parents. These did not relate to the factual accuracy of this report and have been addressed in separate correspondence.

18. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Dartmoor

19. HMP Dartmoor holds up to 642 adult male prisoners. Dorset Healthcare Unit Foundation Trust provides healthcare at the prison.

20. The prison kitchen is a large, modern, industrial space, with a staff office in the middle. There is no CCTV in operation in the kitchen and Dartmoor is in the process of assessing the cost of installing it. Up to 25 prisoners work in the kitchen, and are supervised by civilian staff. No prison officers are on duty in the kitchen. Prisoners are vetted before being allocated to work in the kitchen. They are trusted to use the knives and other utensils, and these are signed out to each prisoner individually and then signed back in. The knives hang on a 'shadow board' which has an outline of each utensil marked on it. When staff issue a knife to a prisoner, a tag with that prisoner's name is hung in its place.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Dartmoor was in December 2013. There was evidence of violence and too many prisoners felt unsafe. The inspectors found that violent incidents were significantly under-reported and there was little support for victims. Prisoner safety was compromised by the availability of prohibited drugs (including synthetic cannabinoids such as new psychoactive substances (NPS), injectable drugs, tradable medication and illicitly brewed alcohol).

Independent Monitoring Board

22. 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 September 2016, the IMB reported their concerns about how Dartmoor managed prisoners who had witnessed Mr Cusworth's murder. They noted that this was an exceptional and unusual tragedy, and that the prison had learned important lessons from it.

Previous homicides at HMP Dartmoor

23. Mr Cusworth was the first prisoner to be murdered at Dartmoor.

Risk assessment and decision making process to work in the kitchen at Dartmoor

24. Dartmoor's employment policy (in operation in September 2015 when Prisoner X was assessed for his suitability to work in the kitchen) said the Prison Employment Unit would allocate a job to a prisoner based on:

- Information in a prisoner's individual learner plan and skills action plan;
- Information in the Offender Assessment System (OASys) about a prisoner's risks and needs; and
- Assessment of a prisoner's risk, need and suitability.

25. Before a prisoner was allocated to a job, a prisoner's health needs had to be assessed and the Prison Employment Unit had to check that the allocation met the security requirements of the relevant prison area.

26. A prisoner's allocation to a job was subject to change if Dartmoor identified additional employment, training or learning needs during a prisoner's sentence planning process or if a prisoner was assessed as being unsuitable for a particular work area.

27. To decide whether a prisoner was suitable to work in the kitchen, the process at Dartmoor was that the employment board – which comprised the head of learning and skills, staff from industries, the career service and the activities department - would email the security department who would check the prisoner's security intelligence record for entries in the previous 12 months about violence, poor behaviour or attempts to escape. If there was evidence of any of these, the security department would not recommend that a prisoner be allocated to work in a high risk area such as the kitchen.

28. The senior management team at Dartmoor reviewed their employment risk assessment processes after Mr Cusworth's death and the security department revised their pre-employment security checks to make the risk assessment process more robust and evidence-based. The revised risk assessment required that the security department considered and scored a number of factors, including whether a prisoner had:

- Been convicted of murder or attempted murder with a bladed weapon;
- Any proven disciplinary hearings for assault in the past 12 months;
- A history of violence;
- An OASys score which indicated a high or very high risk of harm in to staff and prisoners in prison;
- Any proven disciplinary hearings in the past 12 months.

29. A prisoner's score indicated whether a prisoner posed a high, medium or low security risk and this would determine whether a prisoner was suitable to work in a particular work area. Prisoners are assessed as suitable for work in the kitchen if they are low or medium risk. High risk prisoners are not deemed suitable.

Key Events

Mr Alexander Cusworth

30. On 21 February 2015, Mr Cusworth was remanded to HMP Exeter, charged with wounding with intent to cause grievous bodily harm.

31. On 15 May, Mr Cusworth was sentenced to eight years in prison.

32. On 27 May, Mr Cusworth was transferred to HMP Dartmoor.

33. In August, Mr Cusworth applied for work and on 4 September, the employment board at Dartmoor approved Mr Cusworth's application to work in the kitchen. The security department confirmed they had no intelligence that Mr Cusworth should not work in the kitchen.

34. On 5 September, Mr Cusworth started work in the kitchen.

Prisoner X

HMP Exeter

35. On 30 July 1996, Prisoner X was remanded to Exeter, charged with murdering his ex-partner and in 1997, received a life sentence, with a minimum tariff of 15 years. He served time in a number of prisons.

36. In June 2002, Prisoner X assaulted a prisoner. In January 2003, he assaulted another prisoner with whom he had worked. The two men had argued frequently. When the other prisoner tried to throw a kettle of boiling water over him, he stabbed him in the hand with a pencil. He was convicted of actual bodily harm and was sentenced to an additional three months in prison.

37. During the first eight years of his sentence, Prisoner X completed offending behaviour programmes on anger management, drug and alcohol misuse and developing better thinking skills. His risk factors included the use of sadistic violence and weapons. In February 2004, he moved to HMP Gartree to join their therapeutic community and stayed there until 2007.

38. A forensic psychologist at Gartree completed Prisoner X's end of therapy report. She described his offence of murder as callous and frenzied and that his victim had been in the wrong place at the wrong time when he became angry. She noted that he posed a high risk of murder. He acknowledged that he still had the capacity to be a highly violent and callous individual. She described his 'Achilles heel' as events or comments he perceived to be personal attacks. He attributed his violent behaviour to psychosis resulting from his prolonged use of amphetamines and the anger he felt about his childhood abuse.

39. The therapeutic community's therapist, described Prisoner X as a valued group member who displayed a thoughtful and concerned approach. He was never violent at Gartree. He did not complete his therapy as he said he had dealt with his specific issues. It was not considered that he had substantially reduced his risk factors and he was not recommended for transfer to an open prison. He agreed to further therapy.

40. In August 2007 and without provocation, Prisoner X hit another prisoner whom he described as a 'child killer'. In April 2008, staff received intelligence that he had threatened to stab another prisoner who had accused him of dealing medication. In August 2008, he stabbed another prisoner in the neck with a sharpened paint brush. The victim was the prisoner whom he had assaulted the year before.

41. In January 2009, staff received intelligence that Prisoner X was carrying a bladed weapon and intended to assault another prisoner. Staff found the weapon when they searched his cell.

42. In January 2010, Prisoner X's mood deteriorated and he had violent thoughts after a GP stopped his antipsychotic medication. He admitted making weapons, rehearsing violent fantasies and he threatened to harm the GP who had stopped his medication. He said that he was going to stab a prisoner with whom he worked in the laundry but instead, tried to kill himself to prevent himself from doing so.

43. In April 2010, the Parole Board reviewed Prisoner X's case. They assessed that he remained a high risk of serious harm to the public and should stay in closed conditions. They said a move to an open prison was unrealistic. He was advised to complete the following interventions to reduce his risk:

- Controlling Anger and Learning to Manage It course;
- Rehabilitation for Addicted Prisoners trust (RAPt) substance misuse course;
- Cognitive Self Change Programme; and
- Healthy Relationships Programme.

44. In September 2010, another prisoner claimed that Prisoner X had 'nearly stabbed' him. In October, he gave in a handmade weapon, a sharpened fork. He said that he was struggling with prison life and would have hurt either himself or someone else.

45. In January 2011, Prisoner X told an officer that he had violent thoughts towards others and was making weapons in his cell. Staff searched his cell and he handed over a razor blade which had been melted into a plastic handle.

46. Prisoner X completed the Controlling Anger and Learning to Manage It course between January and March 2012. He was described as polite, quiet and well behaved. In October, he was made a Category C prisoner.

HMP Dartmoor

47. In February 2013, Prisoner X was moved to Dartmoor. He had always been considered a vulnerable prisoner because of his offence. Unlike most prisons which hold vulnerable prisoners in a separate unit, Dartmoor runs an integrated regime, where vulnerable prisoners live on wings alongside the general population. He was anxious about this and reception staff reassured him that the majority of the prisoners were vulnerable and the few prisoners from the general population held trusted jobs.

48. On 11 February, Prisoner X applied for work in two areas: the kitchen and tea packing. He noted in his application that he had worked in kitchens in a few prisons and wanted to work in catering after his release from custody. An officer from the security department supported his application. He noted that his behaviour was good, that he had not had any disciplinary hearings or negative reports at Dartmoor but that his OASys assessment indicated he posed a medium risk due to an escape alert. The catering manager noted in his application that he was happy to employ him as a kitchen worker.

49. The officer completed Prisoner X's work activity risk assessment. He noted Prisoner X's conviction for murder and his long history of violence, but that he did not have a history of violence in prison. He recorded that there was no evidence that Prisoner X should not handle tools or be left unsupervised. He recorded the overall risk as medium. Prisoner X started work in the kitchen on 18 February.

50. In March, a custodial manager received information from the healthcare team that Prisoner X had stabbed a former cellmate at a previous prison and had claimed to have stabbed a prisoner at Dartmoor. He checked Prisoner X's record and found that he had previously received a six month sentence for stabbing a prisoner at a previous prison. He found no evidence to support the admission that he had stabbed a prisoner at Dartmoor. He noted that Prisoner X's cell sharing risk remained high. He did not complete a security information report about Prisoner X's admission, and he continued to work in the kitchen.

HMP Erlestoke

51. On 6 December, Prisoner X was transferred to Erlestoke to complete the RAPt course and the Healthy Relationship Programme.

52. In January 2014, Prisoner X's offender supervisor at Dartmoor wrote a sentence planning and review report. He recommended that Prisoner X should not be released or moved to an open prison until he had completed the Healthy Relationship Programme and RAPt course. In February, Prisoner X's offender manager in the community completed a parole assessment report which echoed the previous offender supervisor's recommendation. She noted that Prisoner X was willing to work on his risk factors but had not yet fully addressed them.

53. In April, the Parole Board considered Prisoner X's case again. His behaviour had been good since his last review but the Board recommended that he should not be released or moved to an open prison until he had completed his remaining risk reduction work. Although the Board took this decision in April, the National Offender Management Service did not write to him advising him of next steps until February 2015. His next Parole Board review was scheduled for January 2016 to give him time to complete his offending behaviour work.

54. Prisoner X completed the RAPt programme in June. In December, staff described him as a settled and reserved prisoner. He began the Healthy Relationship Programme in December. In one of these sessions, he said, 'If people take the piss out of me, I'll do it back to them'.

55. In January 2015, Prisoner X told a course facilitator that he was struggling with the Healthy Relationship Programme and that it stirred emotions which made him

consider cutting his wrists. He said that his girlfriend, family and children had severed contact with him. He had recently withdrawn from his usual Buddhist, Alcoholics Anonymous and Narcotics Anonymous meetings and had used new psychoactive substances (NPS). The facilitator agreed not to begin suicide and self-harm prevention procedures if he communicated with staff. He completed the Healthy Relationship Programme in March.

56. In May, Prisoner X asked a female prison officer for a word in private. While in a secluded area, he disclosed inappropriate sexual thoughts and tried to touch the officer's arm. He received a disciplinary hearing and apologised to the officer.

57. On 14 August, Prisoner X decided to protest his innocence about his original offence based on new information. He started a hunger strike, went to the segregation unit in protest and refused to leave. He received a disciplinary hearing for refusing a direct order to return to his cell and was placed in cellular confinement in the segregation unit.

58. On 17 August, Prisoner X's new offender manager in the community completed an OASys risk assessment for him and noted he presented a high risk to the public and adults he knew and a medium risk to prison staff and prisoners. She noted that she had not assessed his education, training and employment as being linked to his risk of harm or offending behaviour but that any future work should take this into account.

59. The offender manager noted that when Prisoner X was under emotional or psychological pressure, he struggled to stop himself harming others. Yet, she noted that it had been a number of years since he had assaulted another prisoner or used weapons in prison. He had completed the RAPt programme and the Healthy Relationship Programme. She was unable to say that he had reduced his risk because he had only completed the Healthy Relationship Programme a short time earlier. She cautiously recommended a progressive move to an open prison.

60. In September, Prisoner X's offender supervisor at Erlestoke completed a sentence planning and review report. He noted that, until recent events, he had been minded to recommend that he move to an open prison. Despite this, Prisoner X's recent segregation and refusal to comply with the prison regime meant that he felt unable to do so.

HMP Dartmoor

61. On 9 September, Prisoner X was transferred to Dartmoor. His person escort record noted that he was a risk to staff, he had a conviction for harassment and had links to drugs and mobile phones in prison. He told reception staff he was happy to have returned to Dartmoor.

62. On 10 September, Prisoner X saw a nurse from the mental health team. She recorded that he was taking aripiprazole (an antipsychotic medication) and communicated well.

63. At a mental health team meeting on 14 September, the nurse recorded that Prisoner X was stable. She referred him for a medication review, but this did not take place before he attacked Mr Cusworth.

64. In September, a registered forensic psychologist assessed in his sentence planning and review report that Prisoner X's violent behaviour had reduced over recent years but that he could become violent to others if he felt threatened, thwarted, angered or challenged. He noted that his risk of serious harm to others in prison was low to medium without a weapon.

65. The psychologist recommended that Prisoner X should not move to an open prison or be released on licence but instead, should stay in a closed prison and consolidate his learning from offending behaviour programmes. He recommended that Prisoner X apply to move to a Psychologically Informed Planned Environment (PIPE) unit. (The National Offender Management Service established PIPE units to treat personality disorders.) He was disappointed by the psychologist's recommendations, but remained respectful. His prison record noted that the psychologist had advised wing staff to monitor his mood and behaviour. Despite this, there were no subsequent entries in his prison record about his behaviour.

66. On 14 September, Prisoner X met a careers adviser as part of his induction to education and employment. He said his preference for a job was to work in the kitchen. He gave two alternatives of textiles and the laundry. His skills action plan did not refer to his risk or history of using weapons.

67. On 16 September, the employment board approved Prisoner X's application to work in the kitchen after they had considered his skills action plan. He started work there the next day. As part of the pre-employment checks, the security department confirmed they had no intelligence to indicate that he should not work in the kitchen. The former Head of Security said that his staff would have checked his security record. The Chair of the employment board, who was the Head of Learning and Skills, told the investigator that he did not remember the decision making process when the board considered Prisoner X's application, and Dartmoor did not provide evidence to confirm exactly what documents they had reviewed when they considered his application.

68. On 2 October, the Parole Board reviewed Prisoner X's case, but decided that it should proceed to an oral hearing in 2016 before they made a final decision.

69. On 9 October, the offender supervisor met Prisoner X to discuss his recent directions letter. He said he had bought 'Spice' (an NPS) in early 2015 but had decided not to use it and had flushed it down the toilet. The offender supervisor recorded that he was not enthusiastic about moving to a PIPE unit.

70. On 16 November, the offender supervisor saw Prisoner X about a potential move to a PIPE unit. This time, he was more receptive and provisionally agreed to be referred.

26 November 2015

71. On 26 November, Mr Cusworth and Prisoner X arrived for work in the kitchen at 1.30pm, the start of the afternoon shift. There were three members of civilian staff supervising the prisoners. Mr Cusworth greeted the prison caterer when he arrived. No prison officers were present. The prisoners began preparing ingredients.

72. Prisoner X was working in the vegetable preparation area with two other prisoners. The prison caterer said she issued three identical kitchen knives for them to use. She told the police that Prisoner X had been 'as normal as ever' when he collected his knife.

73. At about 2.55pm, the three civilian staff members had an ad-hoc meeting in their office, which was slightly raised in the centre of the kitchen. The prisoners were left to continue with their work. Mr Cusworth was working at a food preparation station in the bakery area in the far left hand corner of the kitchen with two prisoners. They were peeling eggs, so none of them had a knife. A moveable notice slightly obscured the view from the office. However, the kitchen staff were not looking into the kitchen preparation area where the attack happened and the board would only have slightly obscured their view as they were sitting down.

74. The prisoners said that Prisoner X suddenly walked over to where Mr Cusworth was working and without any warning, stabbed him in the back with a kitchen knife which had been issued to him so that he could prepare vegetables. The blade pierced Mr Cusworth's renal artery. He inserted the blade once and then walked away. Mr Cusworth collapsed to the floor. One of the prisoners told police that Prisoner X had said to Mr Cusworth, 'You won't fucking talk to me like that again'. The prisoner declined to be interviewed for this investigation.

75. The incident happened so quickly that the prisoners were initially confused about why Mr Cusworth had fallen to the floor until he said he had been stabbed and asked for help. A prisoner placed a jacket under Mr Cusworth's head. None of the staff in the office heard any noise or disturbance. There are no CCTV cameras in the kitchen.

Emergency response

76. The prison caterer was leaving the office when she saw a prisoner gesturing to her. She was the first member of staff to reach Mr Cusworth. He was lying unconscious, on his left hand side on the floor. The prisoner told her that Mr Cusworth had been stabbed. Seconds had passed since the stabbing. At first, she thought that he was joking because she could not see any blood, but at 3.04pm, she radioed a message which said, 'Healthcare to the kitchen immediately'. She told the police that she did not use a code red (which indicates an emergency when there has been a loss of blood) because she had not seen the wound or weapon and did not know whether Mr Cusworth had been stabbed.

77. The prison caterer rolled Mr Cusworth over and saw his wound. She asked the prisoners to get help. One prisoner fetched the kitchen manager from the office. She used latex gloves and paper towels and applied pressure to Mr Cusworth's wound. The kitchen manager joined her and seized the knife, which was lying on the vegetable preparation work surface covered in blood, as evidence.

78. The designated emergency response nurse attended the kitchen with an emergency response bag. She told her colleagues to stay in the healthcare centre (which was 30-60 seconds away from the kitchen) until she knew what was happening. The prison caterer told her that Mr Cusworth had been stabbed. The nurse could not find a pulse and Mr Cusworth's breathing was laboured.

She radioed a code red emergency and requested a defibrillator and oxygen. She gave two breaths and saw Mr Cusworth's chest rise.

79. At around 3.05pm, control room staff called the ambulance service.

80. A prisoner was on a cigarette break at the time and said that Prisoner X joined him, lit a cigarette and calmly told him, 'I fucked up, fucked up big, stuck a ten inch blade in Alex'. Meanwhile, the catering manager and kitchen manager moved the prisoners into the rest room at the opposite end of the kitchen.

81. A number of nurses and a GP attended. Two nurses brought oxygen and the defibrillator. A healthcare assistant brought extra oxygen bottles. A nurse and the healthcare assistant returned to the healthcare centre to collect fluids and syringes. A nurse took over from the prison caterer, applying pressure to Mr Cusworth's wound.

82. A nurse started cardiopulmonary resuscitation. Two nurses applied the defibrillator which advised against shocking Mr Cusworth, so they continued with chest compressions. They maintained pressure on Mr Cusworth's wound and gave him oxygen. Blood flowed from Mr Cusworth's wound and he remained unresponsive.

83. At 3.12pm, control room staff called the police. At 3.19pm, paramedics took over Mr Cusworth's care and gave him fluids and adrenaline. At 3.49pm, Mr Cusworth was taken to hospital, but sadly died at 4.48pm.

Events after Mr Cusworth's death

84. The police questioned all the prisoners who were in the kitchen when the incident happened, and identified Prisoner X as the perpetrator. He was taken to a police station for further questioning. After Mr Cusworth's death, one of the prisoners, who declined to be interviewed by the investigator, told the police that he had heard rumours that Prisoner X had asked Mr Cusworth for a cigarette. Mr Cusworth had allegedly told him, 'Fuck off, I am not giving you one. You're a nonce'.

Contact with Mr Cusworth's family

85. The Head of Offender Management was appointed as the family liaison officer and telephoned Mr Cusworth's mother at 4.20pm. He told her that Mr Cusworth had been stabbed, was in a critical condition and was being taken to hospital. At 4.50pm, he heard from the hospital that Mr Cusworth had died. At 4.55pm, he telephoned Mr Cusworth's mother and broke the news to her. The next day, a police family liaison officer travelled from Exeter to see Mr Cusworth's parents. Although there was a delay, the prison contributed to the cost of Mr Cusworth's funeral in line with national instructions.

Support for prisoners and staff

86. After Mr Cusworth's death, a Governor 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 also offered support.

87. A Governor issued notices informing prisoners of Mr Cusworth's death and offering support. Officers and members of the chaplaincy team supported prisoners. Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Cusworth's death.

Post-mortem report

88. The post-mortem examination found that the cause of Mr Cusworth's death was a single stab wound to the abdomen.

Findings

Employment risk assessment

89. The National Security Framework requires prisons to operate a risk assessment process for prisoners working in areas which hold equipment such as knives including considering whether prisoners are suitable to work in medium/high risk areas, whether there is adequate supervision and whether the equipment might pose a security risk.

90. Dartmoor's local policy on assessing prisoners' security risk required the security department to consider records made in the previous 12 months about violence, poor behaviour or attempts to escape.

91. Before Prisoner X started working in the kitchen at Dartmoor, security staff assessed his risk but confirmed to the employment board that they had no intelligence to indicate that he was unsuitable to work in the kitchen. Dartmoor failed to provide evidence about their decision making process when they assessed his risk, and we have seen no evidence that they considered his OASys risk, whether he was trustworthy to handle kitchen equipment, be left unsupervised or what level of risk he posed to others working in the kitchen.

92. Prisoner X had been convicted of murder, had a long history of violence and had assaulted a number of other prisoners with weapons over a number of years. Yet, his behaviour had improved and there were no entries about him behaving violently or trying to escape in his security records dating back 12 months before his risk assessment. He had last attacked another prisoner in 2008 and had last been found with a weapon in 2011. The security department would therefore not have identified these historic incidents as part of their standard risk assessment process.

93. Prisoner X had also previously worked in the kitchen at Dartmoor in 2013 without incident. Despite this, information that he had allegedly assaulted another prisoner in 2013 had not been recorded in his security records and was never taken into account in reviewing his suitability to work in the kitchen in 2013. It follows that this never formed a part of the consideration of his security risk in 2015.

94. Our Learning Lessons report on prison homicides, which we published in December 2013, noted that a common theme was that staff did not always have access to or fully consider relevant information in prison records which should have been available to them. In this case, Dartmoor's local security process was deficient and meant that the assessment of Prisoner X's risk was not fully informed, taking into account all his risk factors.

95. Dartmoor revised their employment risk assessment process after Mr Cusworth's death. When we applied the revised process to Prisoner X's circumstances, we found that he would be assessed as posing a medium risk. This means that he would still have been approved to work in the kitchen despite his long history of violence in prison and use of bladed weapons against others. We recommend that:

The Governor and Head of Security should ensure that the security process takes into account all relevant factors about a prisoner's security risk when assessing their suitability for a job and that they record the reasons for their decision.

Level of risk and supervision

96. Prisoners are not closely supervised by staff when they work in the kitchen, even though it is a high risk work environment. Staff allocate tasks to prisoners and they are then left to complete them. Prisoners are trusted to complete tasks and their work is checked by staff. Shortly before Prisoner X stabbed Mr Cusworth, the kitchen team had an ad-hoc meeting. The office notice board slightly obscured their view of the kitchen, and they were not looking into the kitchen area when he attacked Mr Cusworth.

97. While kitchen staff might not have prevented Prisoner X's actions on the day as it was unexpected, we are concerned that prisoners, including those at medium risk of harm to others, were left unsupervised, with access to high risk equipment. We make the following recommendation:

    The Governor should ensure that prisoners are adequately supervised in high risk work areas.

98. The kitchen manager told the investigator he was not aware of any ill feeling between Prisoner X and Mr Cusworth. There had been no disciplinary issues involving Mr Cusworth or Prisoner X while they had worked in the kitchen. The kitchen staff told the investigator that they had never witnessed an incident in the kitchen involving either of the two prisoners. Another prisoner who worked in the kitchen told the police that Mr Cusworth had sworn at Prisoner X and refused to give him a cigarette. In the absence of any other evidence, we cannot conclude whether or not this happened. At his trial, he denied that he had attacked Mr Cusworth and we cannot know what triggered his actions on 26 November 2015.

Clinical care

99. The clinical reviewer reviewed the clinical care Mr Cusworth and Prisoner X received at Dartmoor. He was satisfied that their care was equivalent to what they could have expected to receive in the community.

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