

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malacai Samson, a prisoner at HMP Pentonville, on 23 August 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

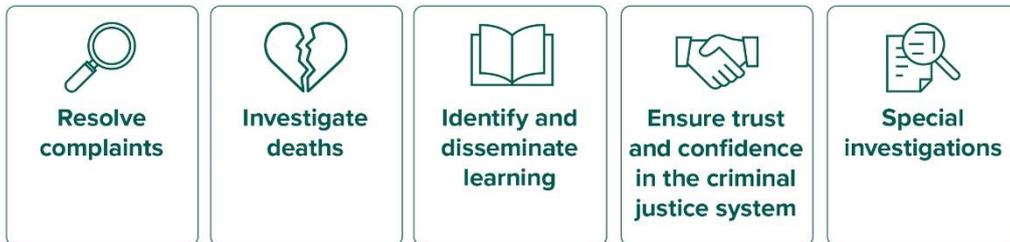
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

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

On 22 July 2019, Mr Malacai Samson barricaded himself in his cell at HMP Pentonville and began hanging himself as staff were trying to gain entry. He was resuscitated but died in hospital on 28 August, having never regained consciousness. He was 32 years old. I offer my condolences to Mr Samson's family and friends.

Mr Samson moved from a mental health unit to Pentonville in November 2017, as a short-term move ahead of an intended transfer to a suitable long-term prison. Despite the plan to move him on, Mr Samson remained at Pentonville for the next 20 months, primarily because he was resistant to moving to any prison where he would have to engage in the group therapy work he needed to do for his sentence plan.

Mr Samson remained at Pentonville for far too long and I am concerned that no proper consideration appears to have been given to transferring him to a new offender supervisor when the relationship with his existing offender supervisor appeared to have broken down.

While I consider that Mr Samson was generally well supported through suicide and self-harm prevention procedures, some aspects were not managed so well. I am concerned that meaningful caremap actions were not set and that insufficient thought was given to Mr Samson's risk of suicide and self-harm at the final case review and in the hours before he hanged himself.

Although staff believed that they needed to gain entry to Mr Samson's cell on 22 July, given his threat to take his life that evening, I consider that they should have considered other options to keep Mr Samson safe and note that local procedures to inform the duty governor were not followed.

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

Adrian Usher
Prisons and Probation Ombudsman

December 2023

Contents

Summary	1
The Investigation Process.....	2
Background Information.....	4
Key Events.....	7
Findings	20

Summary

Events

1. In July 2007, Mr Malacai Samson was remanded in custody, charged with the murder of his mother. In April 2008, he was convicted and sentenced to life imprisonment for a minimum term of 14 years. Mr Samson had spent time at several different prisons until November 2014, when he was admitted to the Millfields Unit (a secure unit for prisoners diagnosed with personality disorders), where he was diagnosed with antisocial and borderline personality disorders.
2. In November 2017, Mr Samson was discharged from the Millfields Unit and sent to HMP Pentonville. The aim at Pentonville was first to allow Mr Samson a period of time to become more stable, before his transfer to a prison that delivered the programmes and pathways that met his sentence plan.
3. At his initial meeting with his offender manager, Mr Samson said that he wanted to transfer from Pentonville as soon as possible. However, in subsequent meetings with her, and other staff, Mr Samson maintained that he would not transfer to a prison where he would have to engage in the group therapy work his sentence plan required. In addition, Mr Samson made frequent threats of suicide or self-harm and was monitored under suicide and self-harm prevention procedures, known as ACCT. Mr Samson obtained razors with which he cut himself at times. He also made threats towards his offender supervisor and appeared to believe that she was responsible for his failure to progress through the system.
4. In April 2019, Mr Samson spoke to his offender supervisor about returning to the Millfields Unit. She sent a referral, although this was not supported by Pentonville's healthcare team. In response, a clinician from the Millfields Unit came to Pentonville to interview and assess Mr Samson.
5. On 19 July, Mr Samson's offender supervisor told him that the Millfields Unit would not readmit him but recommended that he should be transferred to a prison for group therapy work. Mr Samson said that he had started food refusal and an officer noted that day that he continued to make threats about taking his life, that he was not eating and appeared frail.
6. During the afternoon of 22 July, Mr Samson barricaded his cell and told other prisoners that he was going to kill himself. A custodial manager and a supervising officer tried to persuade him to remove the barricade, which he refused to do. The custodial manager then collected equipment to force entry into the cell. He found that the bolt securing the third hinge was damaged and difficult to remove, which caused a delay to opening the cell door. Mr Samson said that he would not allow staff to come into the cell. While they were trying to open the door, Mr Samson sat on the window ledge and tied a ligature around his neck and to the window bars before letting himself slide off the ledge. The supervising officer radioed that Mr Samson was hanging. Staff were able to enter the cell around eight minutes later and nurses began cardiopulmonary resuscitation (CPR).
7. Paramedics arrived at 7.40pm and established a pulse. Mr Samson was taken to hospital and placed in intensive care. He died in hospital on 23 August.

Findings

8. Managing Mr Samson provided staff at Pentonville with considerable challenges. While some positive actions were taken, and it is apparent that many staff knew and understood the issues surrounding his care, there were some areas where this care might have been improved.
9. Mr Samson was appropriately monitored under ACCT procedures in the time before he hanged himself. However the ACCT caremap did not include a plan to address some significant areas of risk, including the news that he could not return to the Millfields Unit. We also found that staff underestimated Mr Samson's risk of suicide and self-harm at the final case review and in the hours before he hanged himself.
10. Mr Samson's offender supervisor referred him to the Millfields Unit without the support of Pentonville's healthcare team. When she arranged to tell him that the Millfields Unit would not take him back, there was no apparent thought given to his immediate support needs on hearing the news.
11. Staff did not take any action when Mr Samson began refusing food. They did not monitor and record his food intake and did not consider the impact on his risk of suicide and self-harm.
12. On the day that Mr Samson hanged himself, the custodial manager did not inform the duty governor that he had barricaded himself in his cell. The damage to the door hinge securing bolt had not been identified by officers while making their daily cell fabric checks.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:
 - support actions are set that are specific, meaningful and identify all of the issues identified at assessment interviews and case reviews, including ensuring that appropriate support is provided when difficult news is given to a prisoner at risk of suicide and self-harm;
 - prisoners' access to razors is managed in line with national instructions; and
 - case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.
- The Governor should ensure that prison offender managers (previously known as offender supervisors) are given appropriate support where needed, including that:
 - prison offender managers are accompanied by a senior colleague, where appropriate, in reiterating difficult messages to prisoners; and
 - prisoners are reallocated to a new prison offender manager when the relationship with the existing offender supervisor has broken down.
- The Governor and Head of Healthcare should ensure that all staff at Pentonville understand that referrals to secure mental health units should only be made through the prison's mental health Inreach team.

- The Governor and Head of Healthcare should ensure that staff manage a prisoner who is refusing food in line with national guidelines.
- The Governor should ensure that staff inform the duty governor when a prisoner has barricaded himself in his cell and that staff consider all options, including use of trained negotiators, when dealing with prisoners who are threatening suicide or significant self-harm.
- The Governor should share a copy of this report with CM A and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Governor should ensure that officers check the condition of door hinge securing bolts when making their daily cell fabric checks.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded, one anonymously.
14. The investigator obtained copies of relevant extracts from Mr Samson's prison and medical records. He interviewed 16 members of staff and three prisoners at Pentonville between September 2019 and May 2020. Interviews carried out in April and May 2020 were conducted by telephone due to revised working practices during the COVID-19 pandemic. The investigation was subsequently transferred to one of the investigator's colleagues, who interviewed one further witness.
15. NHS England commissioned two clinical reviewers to review Mr Samson's clinical care at the prison. The investigator and one of the clinical reviewers jointly interviewed clinical staff.
16. We informed HM Coroner for London Inner North of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. The Ombudsman's family liaison officer contacted Mr Samson's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Samson's brother did not respond.
18. We shared our initial report with HMPPS but were unable to contact Mr Samson's brother. HMPPS did not identify any factual inaccuracies in our report.

Background Information

HMP Pentonville

19. HMP Pentonville is a local prison serving the courts of north and east London and holds up to 1,310 men. Practice Plus Group, in partnership with Enfield and Haringey Mental Health Trust, provides healthcare services at the prison.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Pentonville was in July 2022. Inspectors found that there were serious deficiencies in the performance of the offender management team which had suffered from poor leadership, oversight and a failure to maintain basic processes. Fragile improvements had been made which were threatened by staff shortages and poor morale. All sentenced prisoners now had a prison offender manager (formerly known as offender supervisors). Inspectors found the quality of case management was variable, and that until recently, prison offender managers had been managing high risk cases without probation support or supervision. They found that in most cases, there was little evidence of any structured work with prisoners.
21. Inspectors found that the key worker scheme was not functioning and there was little evidence that wing staff were actively assisting prisoners with sentence and release planning.
22. Inspectors found that support for prisoners in crisis and those subject to ACCT procedures was not good enough, and ACCT case management was weak. While the ACCT case reviews were sufficiently detailed, associated care plans were often incomplete or not used effectively to deliver tailored care and relevant support. Inspectors found that senior leaders were aware of these concerns and had advanced plans to improve case management, including ongoing training and the use of named case managers. There was insufficient leadership and oversight of suicide and self-harm prevention work.

Independent Monitoring Board

23. 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 annual report for the year to March 2020, the IMB recorded its view that many of the prisoners at Pentonville had complex and multiple needs which a local prison, serving the local courts, was ill equipped to address. The IMB also reported problems in timeliness in responses for information from the offender management unit (OMU), which the IMB acknowledged was often for reasons outside the OMU's control as they were often dependent on information from other bodies, such as the probation service.

Previous deaths at HMP Pentonville

24. Mr Samson was the fourth prisoner to die at Pentonville since April 2017. Of the previous deaths, two were self-inflicted and one was from natural causes. Our

investigations into the two self-inflicted death found that staff underestimated the prisoners' potential risk of suicide or self-harm.

25. There was a further self-inflicted death in August 2019 when we again found that staff underestimated the prisoner's risk of suicide or self-harm.

Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

27. On 30 July 2007, Mr Malacai Samson was remanded to HMP Feltham, charged with the murder of his mother. He was convicted on 1 April 2008 and sentenced to life imprisonment for a minimum term of 14 years. After spending time at HMP Swaleside and HMP Elmley, Mr Samson moved to HMP Long Lartin in July 2009.
28. In November 2014, Mr Samson was admitted to the London Personality Disorder Unit (the Millfields Unit), for assessment and treatment of his diagnosis of schizophrenia and because of his history of self-harm. While at the Millfields Unit, he was diagnosed with antisocial personality disorder and borderline personality disorder.
29. On 28 November 2017, Mr Samson was transferred from the Millfields Unit to HMP Pentonville, the prison local to the Unit. In a discharge summary the Millfields Unit's Lead Clinician and Head of Service wrote that, by the autumn of 2015, Mr Samson had made no progress with his treatment targets. She wrote that staff at the Millfields Unit had referred Mr Samson to HMP Gartree's therapeutic unit, but Gartree declined to accept him due to an historical sexual offence. She wrote that the decision to transfer Mr Samson to Pentonville was in line with national policy and the Unit would support his onward referral to a more suitable prison.
30. On arrival at Pentonville, Mr Samson said that he had consistent thoughts of suicide and self-harm and staff started suicide and self-harm prevention procedures, known as ACCT. Mr Samson had been supported through ACCT a number of times while at previous prisons.
31. In December, Mr Samson was assessed by the prison's Enhanced Support Service (ESS) team. A psychiatric nurse told the investigator that the role of the ESS team was to support prisoners with significant behavioural problems with the aim to resolve the problem within three months. He said that Mr Samson did not have a severe or enduring mental health illness, so he did not strictly meet the ESS team's criteria for support, but they took him onto their caseload following a request from their commissioning body.
32. On 18 January 2018, Mr Samson was introduced to his offender supervisor. She told him that she was going to arrange a meeting to include Mr Samson's offender manager to explore transfer options. Mr Samson said that he wanted to transfer as soon as possible.
33. On 7 March, the offender supervisor and offender manager met Mr Samson to discuss his transfer and other objectives. The offender supervisor told the investigator that the plan was to move Mr Samson to a prison with an appropriate pathway for his sentence plan, but he was not ready to transfer at that stage as he needed to become more settled and stable and that the ESS team were helping him with that.
34. At an ACCT case review on 8 March, Mr Samson said that he had mixed feelings about his meeting of the previous day as he was unsure whether he would prefer to transfer to another prison or remain at Pentonville until his re-categorisation review

in November, when he hoped he would be re-categorised from category B to category C.

35. On 26 March, prison staff closed the ACCT procedures, having noted that he had made considerable progress in the past months, including building good relationships with the ESS team. Mr Samson said that he had no present thoughts of suicide or self-harm.
36. At the end of April, Mr Samson barricaded his cell with furniture and made some superficial cuts to his arm and chest. He said that he did this as his Xbox had been stolen and he had been given a psychoactive substance against his will. Staff restarted the ACCT procedures and, at Mr Samson's request, moved him to F wing, the vulnerable prisoners' (VP) wing. Mr Samson remained on F wing for the remainder of his time at Pentonville.
37. On 11 May, the offender supervisor told Mr Samson that a pre-tariff sift was due and that the dossier for this needed to be agreed by 1 August. She told the investigator that the pre-tariff sift was to consider prisoners' suitability to move to an open prison. She said that Mr Samson was not suitable for an open prison, but the pre-tariff sift was a process that needed to be completed. She said that she tried to manage Mr Samson's expectations about progress through the prison system and this led to the difficulties that ultimately resulted in their relationship breaking down.
38. On 13 May, officers found Mr Samson hanging from a ligature in his cell. Entries in Mr Samson's records suggest he had grown increasingly paranoid in the previous days and had told the psychiatric nurse that another prisoner had stolen his USB stick on which he had stored music and photographs. Staff supported him through the ACCT process until 1 June, when the ACCT procedures were closed.
39. On 4 July, the psychiatric nurse told Mr Samson that he had been discharged from the ESS team. He said that Mr Samson should speak to his offender supervisor about further options for engaging with offender behaviour programmes and other treatments in support of his sentence planning. He told us that he continued to support Mr Samson on an informal basis.
40. On 13 July, the offender supervisor completed a parole report. She noted that she had had 14 formal meetings with Mr Samson. She wrote that she considered Mr Samson suitable for HMP Grendon's therapeutic community, who had agreed that he was suitable for assessment given his current stability. She added, however, that Mr Samson was resistant to the proposal as the length of the intervention at Grendon would take him past his sentence tariff date. She wrote that Mr Samson believed that he was ready to progress to a category C prison, and then to open conditions, without the need for any psychological input. She wrote that such thinking demonstrated Mr Samson's lack of insight into his risk factors as well as his unrealistic hope of progression at the time. She sent Mr Samson a copy of her report for discussion.
41. On 3 August, the offender supervisor wrote an addendum to her parole report. She wrote that Mr Samson wanted to highlight his difficulty in engaging in group work. She added that she explained to him that that was why she believed a therapeutic community would assist him.

42. On 6 August, staff started ACCT procedures due to Mr Samson's agitation over his parole report. At the first ACCT case review on 8 August, Mr Samson complained that his parole report would prevent his release at the next review. Staff closed the ACCT procedures on 11 September.
43. In September, Mr Samson made a written complaint to say that there were inaccuracies in the offender supervisor's pre-tariff sift report. He asked for the report to be amended and asked to be allocated a different offender supervisor. Her manager responded that she did not have the resources to re-allocate Mr Samson to a different offender supervisor at that time.
44. On 11 October, Mr Samson told a psychiatrist that he had a long list of people he felt had played games with him or had lied to him. He said chief among these was his offender supervisor. He said that he did not want to go to Grendon, but wanted to go to HMP Warren Hill (a category C prison) where the therapeutic groups were small.
45. On 23 October, the psychiatrist emailed the offender supervisor to say that Mr Samson reported feeling full of rage and that he wanted to attack others. She added that she was concerned about the potential risk to her.
46. On 25 October, a member of the ESS team met Mr Samson following a report of him banging his head. Mr Samson said that he felt trapped and was angry that he was not progressing through his sentence. Mr Samson said he might hang himself if he did not receive an adequate response to a query about his last parole review. She started ACCT procedures and arranged to meet Mr Samson for a number of cognitive behavioural therapy sessions. She told the investigator that her involvement was not to treat Mr Samson's personality disorder, but to help him manage his situation. (Mr Samson subsequently completed 18 therapy sessions with her.)
47. Also on 25 October, the offender supervisor emailed Pentonville's OMU, enclosing the psychiatrist's email to her. She said that in light of the deterioration in her working relationship with Mr Samson, it would be helpful for him to have a swift transfer from Pentonville so that he could settle in a more stable environment.
48. On 9 November, the offender supervisor met Mr Samson and noted that he was dissatisfied with her pre-tariff sift report. She recorded that they spoke about prison transfer and that it was time for that to happen given Mr Samson's stability. She said that Mr Samson expressed some anger and said that he did not care where he was going.
49. On 24 November, Mr Samson handed a Will to a Supervising Officer (SO), in which he said that he would kill himself. A Custodial Manager (CM) chaired an enhanced ACCT case review later that day. He recorded that Mr Samson said that if his concerns about his categorisation, sentence planning and transfer were not addressed to his satisfaction by Christmas, he would take his life.
50. On 27 November, a prison manager chaired a complex case meeting with most of the key staff involved in Mr Samson's care. The meeting discussed options for transfer to a number of different prisons, while also noting Mr Samson's resistance to group work. The meeting noted that Mr Samson was focussed on his tariff expiry

of 2021, but also noted that he had not been able to progress since being in Pentonville as the prison did not provide the sentence programmes he needed. The offender supervisor and a SO from Pentonville's offender management unit were asked to take forward the work needed to arrange a transfer.

51. On 28 November, a CM chaired an ACCT case review. An SO recorded that she told Mr Samson about the outcome of the complex case meeting and that they were looking to transfer him to Grendon or Swaleside. Mr Samson said that he wanted to go to a category C prison and wanted one-to-one sessions rather than group work. It was agreed that a member of the ESS team, who attended the case review, would identify prisons that provided clinical intense therapy.
52. On 20 December, at an ACCT case review, Mr Samson left the room when his offender supervisor arrived and said that he would not remain in the same room as her. Mr Samson was discussed in his absence, and she told the review that she and an SO were having difficulty finding another prison to take him because of his historic sexual offence. She told the investigator that she spoke with a prison manager about re-allocating Mr Samson to a different offender supervisor, but it was decided that she should continue in the role.
53. On 24 January 2019, at an enhanced ACCT case review, prison staff recorded that Mr Samson had engaged positively. They closed the ACCT procedures. Mr Samson was told that the strategic safety lead had agreed to review his case and advise on the way forward with his sentence plan and future location. Mr Samson said that he was pleased with the proposal.
54. The strategic safety lead told the investigator that he had been asked to review Mr Samson's file by several of the staff involved in his care, some of whom possibly believed that he was overdue for re-categorisation to category C status. After reviewing Mr Samson's file, he emailed all those directly involved to say:

"I think it is probably sensible that we have a multi-disciplinary meeting ... but I confess that my initial take ... is that there are significant risks attached to Mr Samson and that they are some way away from being resolved. Areas of concern include: significant violent index offence, untreated sexual offending, regular and serious self-harm issues, recent ... acts of serious violence to a third party, unresolved personality disorder concerns ... [I feel] that there is already an emerging pathway towards addressing the concerns above ... There is a positive route open to Mr Samson, but it involves some hard decisions and some difficult work ... I would be very reluctant to sign off on a re-categorisation to category C and ... I [don't] think that should be put forward as a pathway at this time. Having said that, it strikes me that there is option for him to address some of the risk factors within the cat B estate and I would actively support and encourage that."
55. On 25 January, the Prison Service's Public Protection Group wrote to Mr Samson saying that his case would not be referred to the Parole Board before the expiry of his tariff on 1 August 2021. They wrote that there was no realistic prospect that the Parole Board would sanction his transfer to open conditions before then. Mr Samson was advised to work in addressing his risks of reoffending and was advised that Grendon had been identified as an appropriate placement for him. The offender supervisor passed the letter to Mr Samson, with a cover letter to explain

that staff were making efforts to arrange transfer to a prison where his needs could be adequately met and where he could complete his psychologically informed work.

56. In early February, the offender supervisor emailed HMP Wakefield and HMP Garth to ask if they would accept Mr Samson. On 7 February, she contacted the clinical lead at Garth to ask if their Beacon Unit (part of the National Offender Personality Disorder Pathway) was an option for Mr Samson, even if only in preparation for further in-depth work. She explained that Mr Samson had been refused treatment at Grendon and Gartree due to his historic sexual offence.
57. On 18 February, an officer introduced himself to Mr Samson as his new key worker. Mr Samson said that his only aim at that time was to get out of Pentonville and to move to a category C prison. He talked about a meeting scheduled for 21 February, when he expected to be told that he would be asked to move either to a category B prison or to Grendon, and that he did not agree with those options. The officer's records show that he continued to have regular and meaningful contact with Mr Samson for the remainder of his time at Pentonville.
58. On 21 February, the member of the ESS team saw Mr Samson for a psychology session. She noted that Mr Samson was mentally stable, but that he said he was feeling scared and anxious following a meeting that morning when he was told that he was to remain a category B prisoner. She also noted that Mr Samson's transfer had been placed on hold for the next three months to allow him to continue with psychology sessions with her, through which he was making good progress.
59. On 22 February, Mr Samson told a substance misuse worker that he would no longer engage with services at Pentonville and that he would rather die than remain in the prison. She started ACCT procedures. She told the investigator that she first became involved with Mr Samson for possible issues with misuse of cannabis and psychoactive substances, but continued to see him more in the role of a crisis worker.
60. At an ACCT case review on 24 February, Mr Samson said that he was upset when told that he would have to wait a further three months for a categorisation review, but he had no intention of harming himself and would discuss his thoughts with the psychiatrist.
61. On 7 March, the referrals co-ordinator at Garth's Beacon Unit emailed the offender supervisor to say that Mr Samson appeared potentially suitable for their unit. The co-ordinator attached referral forms and added that the admission process would take around four to five months, even if Mr Samson's case was prioritised.
62. On 22 March, prison staff closed the ACCT procedures. Two days later, Mr Samson harmed himself by banging his head against a wall. Mr Samson said that he had heard and seen demons. Prison staff restarted the ACCT procedures. The next evening, Mr Samson was placed under constant supervision for several days.
63. On 26 March, the strategic safety lead chaired a meeting to discuss a team approach in seeking Mr Samson's agreement to move to the Beacon Unit. The offender supervisor explained that Mr Samson's agreement to participate in treatment was an essential prerequisite. She also said that the Beacon Unit's initial response to her approach was the first positive response she had had from the

various prisons she had contacted. The strategic safety lead noted that there were potential hurdles, including Mr Samson's possible refusal to agree to treatment at the Beacon Unit. He said that alternative options needed to be put in place and the meeting agreed that options included a general transfer to the long-term prison estate, which would ideally be to Garth to leave the door open for a later move to the Beacon Unit.

64. A CM chaired an ACCT case review that afternoon, which the strategic safety lead, a psychiatrist and the key worker attended. Mr Samson was told about the possible move to Garth and the strategic safety lead explained to him the re-categorisation process and why he would remain a category B prisoner. Mr Samson agreed that he might be able to re-establish a working relationship with his offender supervisor and agreed that the best way forward might be to move to Garth on normal location with a view to moving to the Beacon Unit in the future.
65. On 28 March, Mr Samson tested positive for a psychoactive substance.
66. On 10 April, at an ACCT case review, Mr Samson said that he trusted that the staff were not lying to him and he was waiting for his transfer as promised. Mr Samson denied any thoughts of self-harm and staff closed the ACCT procedures.
67. On 15 April, a CM told the offender supervisor that Mr Samson had returned the Beacon Unit information pack back to him, saying it was not the place for him, but that he wanted to meet her to discuss a way forward.
68. On 18 April, the offender supervisor told Mr Samson that she would schedule a meeting for the following week to discuss a referral and transfer to a standard wing at Garth. A psychiatrist also met Mr Samson that day and noted that he was concerned about the prospect of mixing with non-vulnerable prisoners at Garth due to the nature of his offence. He said that he had been attacked and threatened in the past by other non-vulnerable prisoners.
69. On 26 April, the offender supervisor met Mr Samson and noted that while he accepted that he needed treatment through the personality disorder pathway, he was anxious about group work and felt that the groups at Garth's Beacon Unit were too large. Mr Samson asked to be considered for a return to the Millfields Unit and the offender supervisor agreed to refer him for potential re-admission. In an email to the Millfields Unit that day, she asked if a return was an option for Mr Samson saying that he believed that he was now clearer on what would be expected of him if he were to return.
70. On 3 May, Mr Samson contacted his offender manager to ask him to support his return to the Millfields Unit. The offender manager replied to say that he had already sent an email supporting the referral.
71. Also on 3 May, the offender supervisor submitted an intelligence report to say that Mr Samson's co-defendant had told her probation officer that Mr Samson had telephoned her mother that day using a mobile telephone. Mr Samson's co-defendant said that Mr Samson had made similar attempts to re-establish contact with her in the past, despite a restraining order prohibiting contact. The offender supervisor noted that Mr Samson's actions showed a clear escalation of risk and coincided with him seeking a return to the Millfields Unit.

72. Following the offender supervisor's referral, a specialist registrar from the Millfields Unit came to Pentonville on 29 May to interview Mr Samson. Mr Samson said that he was working with a psychiatrist and that he hoped to return to the Millfields Unit to engage in small groups. (The specialist registrar subsequently wrote a report with recommendations for Mr Samson's care, and which was disclosed to Mr Samson on 19 July.)
73. On the morning of 31 May, a mobile phone was found in Mr Samson's cell during a security led search. Around an hour later, staff started ACCT procedures when Mr Samson said that he would harm himself if his cell door was opened that day. Mr Samson was placed on hourly observations. He was also suspended from his prison job.
74. On 1 June, Mr Samson told an officer that the mobile phone did not belong to him and he was worried that its discovery would jeopardise his return to the Millfields Unit. He said that he would take his life if he did not return there and he showed the officer a number of razor blades which he said he would swallow if anyone tried to unlock his door.
75. An SO chaired an ACCT review that afternoon with a healthcare representative. Mr Samson refused to come out of his cell but said that he would not kill himself until he found out if he was to be re-admitted to the Millfields Unit. The SO noted that Mr Samson's level of risk was raised. He did not include any caremap actions.
76. Mr Samson refused to attend his next ACCT review, on 3 June, but the ACCT case manager spoke to him at his cell door. Mr Samson said that he would take his life if anyone tried to enter his cell but said he would come out of his cell if he was allowed to go back to the Millfields Unit.
77. Also on 3 June, the offender supervisor emailed the strategic safety lead saying that Mr Samson, by telephoning his co-defendant's mother, had demonstrated his lack of resolve to engage positively with the probation supervision process and asked if it was now time for him to transfer to the long-term prison estate.
78. On 5 June, Mr Samson barricaded his cell door with a cupboard and tied a noose to the cell window bars. He showed an SO a razor blade embedded in a piece of wood which he placed in and out of his mouth. Mr Samson said that he wanted staff to forcibly enter his cell so that he could kill himself in front of them. He remained on hourly observations and no immediate relevant entry was made on his caremap. Mr Samson remained barricaded in his cell for several days.
79. An SO chaired Mr Samson's next ACCT case review on 6 June, which Mr Samson refused to attend and repeated that he was waiting for staff to open his door so he could take his life in front of them.
80. On 9 June, Mr Samson told the night officer that his offender supervisor had made a mistake with his pre-tariff review, which meant that he would have to serve a further eight years before being eligible for a move to an open prison. The night officer submitted an intelligence report to say that Mr Samson said that he would block the key holes and anti-barricade holes of his cell door and if staff entered his cell he would take his life.

81. On the morning of 10 June, an SO told Mr Samson that the situation could not continue, and staff would enter the cell that day, using force if necessary. Mr Samson responded by placing his head in the noose tied to the window bars. The SO asked a psychiatrist to speak to Mr Samson. After speaking to them for some time, Mr Samson agreed to remove the barricade, to surrender the noose and razor blades, and to attend an ACCT case review.
82. An SO chaired an ACCT case review that afternoon. Mr Samson and a psychiatrist attended, as did a Samaritans trained prison Listener, who attended at Mr Samson's request. Mr Samson said that he had a £150 debt to other prisoners, whom he would not name, for losing the mobile phone, and he felt unsafe as a result. He said that he wanted a job off the wing in the recycling or bin teams and the SO agreed that that would be a good way to help him re-integrate onto the wing. Mr Samson's punishment for possession of the mobile phone included 42 days' loss of television. Mr Samson said that he would find that difficult and the SO agreed that he could keep his television subject to good conduct. The SO wrote four caremap actions: to remove the furniture from the cell, to remove the noose and ligature, for Mr Samson to apply for a job and to allow Mr Samson a television. (It is unclear what furniture was removed, but usual practice would be to return a prisoner's furniture within a brief time and this is what happened with Mr Samson.)
83. Over the following days, Mr Samson spent time out of his cell speaking to other prisoners. An officer noted that he was in a much better mood.
84. On 13 June, the psychiatrist noted that Mr Samson was tired and low in mood but was mentally stable. They spoke about the events of the past days and how he might behave differently in the future.
85. At an ACCT case review on 17 June, chaired by an SO, Mr Samson said that he feared that he would not be transferred to the Millfields Unit for the remainder of his sentence. He said that he would then have to go through the process of re-categorising to a category C, then to a category D, which he believed would take him eight years over his tariff. Mr Samson said that he had made progress with the psychiatrist, but he still had suicidal thoughts. The SO reduced Mr Samson's observations to one every two hours.
86. On 18 June, Mr Samson harmed himself by hitting his head against the wall. He told staff that he was not having a good day. A Listener later spoke to Mr Samson.
87. At an ACCT case review on 24 June, Mr Samson said that he regretted harming himself the week before as he was trying to move forward and to get a job and that an SO had said he would help him with this. Mr Samson spoke about transfer to another prison for a fresh start and where he could work with the mental health team. An action point was added to Mr Samson's caremap to contact OMU about prison transfer.
88. On 25 June, the offender supervisor emailed the psychiatrist to say that Mr Samson's recent actions, including his attempted contact with his co-defendant and discovery of a mobile phone, meant that he was unsuitable for the Millfields Unit at that time. She added that she had informed the strategic safety lead in the hope Mr Samson could be transferred to the long-term prison estate, which was part of the original plan.

89. On 28 June, an SO chaired an ACCT review where he noted that Mr Samson said that he was feeling more optimistic about his future and did not want to die. The SO reduced Mr Samson's observations to once every three hours.
90. On 5 July, an SO chaired an ACCT case review. He noted that Mr Samson was frustrated that he was still waiting for an answer about his possible transfer to the Millfields Unit. The SO noted the prospect of closing the ACCT on 16 July, after several key dates had passed: dates of birth of two of his siblings and the anniversary of his offence.
91. On 10 July, Mr Samson told his key worker that everybody agreed Pentonville was not the right place for him, but nothing was being done to move him out. The key worker challenged Mr Samson on this and said that he had witnessed efforts to move him which he had opposed. Mr Samson acknowledged that he had refused a move to Garth, but explained that he would have to do group therapy at that prison which would make him feel vulnerable to attack from other prisoners. Mr Samson said that by November, he would have been at Pentonville for two years, when he was initially told he would only be there for six months.
92. On 10 July, an officer noted a bruise on Mr Samson's forehead. Mr Samson said that he had hit his head on his cell wall after staff refused to let him make a telephone call.
93. On 15 July, Mr Samson told his key worker that he was not in a good mood. He said he was willing to move anywhere just to be out of Pentonville and would harm himself if he had not moved by the end of the year.
94. At around 5.00pm, Mr Samson told an officer that he would refuse food until he was moved from Pentonville. The officer noted that he contacted the prison's offender management unit, who told him that Mr Samson's case was complex and he might not move soon. He then noted that Mr Samson made threats to take another prisoner hostage or assault a member of staff unless he was transferred. Mr Samson also said that he would be "taken away in a body bag" on 27 November (the second anniversary of his transfer to Pentonville). The officer noted that he referred Mr Samson to healthcare for "his own wellbeing". (There is no record in Mr Samson's healthcare record that they received or actioned any such referral.)
95. That day, several of the key staff exchanged emails about Mr Samson. The strategic safety lead wrote that Mr Samson needed to address the areas in his offending history to move successfully through his sentence. He wrote that his understanding was that the work he had been doing with the psychiatrist had aimed to get him into the best position to allow him to address his needs and that, while that was happening, his time at Pentonville had seemed a reasonable compromise for the potential future benefits. He went on to say that in the absence of any clear progress, it was time for Mr Samson to be transferred to a longer term prison.
96. The offender supervisor responded to say that she had received the report from the Millfields Unit, which recommended that Mr Samson's pathway should be prison-based, including treatment through a PIPE unit. She wrote that she agreed with that plan and that she intended to share the report with Mr Samson on 16 July.

97. On 16 July, an SO chaired an ACCT case review with the psychiatrist and Mr Samson. Mr Samson said that he was frustrated that he had heard nothing about his referral to the Millfields Unit. Mr Samson made threats to harm himself or take a hostage if he was still at Pentonville in November. (The strategic safety lead had earlier emailed the SO to say that he could not attend the review but would start the process of looking for a suitable prison to transfer Mr Samson.)
98. On 19 July, an SO chaired an ACCT case review with Mr Samson, at which the offender supervisor disclosed the report from the Millfields Unit recommending that he should be transferred to a PIPE unit with treatment programmes involving group work. The SO noted that Mr Samson said that he had predicted the recommendation. He also said that when he had engaged in this type of work in the past, he had been threatened by other participants and had responded though self-harm. Mr Samson said that he would not engage in any more therapeutic work and wanted to transfer to a prison or unit for vulnerable prisoners. The offender supervisor said that she would give Mr Samson time to reflect on the report and would speak to him again about it. Mr Samson said that he would begin an escalating programme of self-harm, starting with food refusal, which he said he had begun, and culminating in suicide by ligature in November. The SO noted that he believed Mr Samson made the threats partly for affect and he therefore made no change to Mr Samson's level of conversations and observations, which remained at three conversations a day and observations at three-hour intervals. He noted Mr Samson's level of risk as raised. He made no additions to Mr Samson's caremap and set the next ACCT review for 25 July, to allow time for the psychiatrist and offender supervisor to speak to him further about the report. He subsequently emailed a copy of the review to those involved in Mr Samson's care.
99. A Listener told us that the news that he would not be returning to the Millfields Unit affected Mr Samson, as he believed going to a prison such as Grendon would delay his release from custody for several more years.
100. On the evening of 19 July, an officer noted in Mr Samson's ACCT that he continued to have thoughts of taking his life and that he said he was tired of management lying to him. The officer also noted that Mr Samson was not eating, he was losing weight and appeared frail.
101. On the afternoon of 20 July, an officer noted that Mr Samson had still not eaten.
102. On 21 July, Mr Samson told his key worker that Pentonville was meant to be a stepping-stone to move to a category C prison, but he felt that he would never get out of the prison and had started making plans to kill himself. The key worker reminded Mr Samson that he had previously been told what he needed to do to progress, but Mr Samson said it was impossible for him to achieve the goals he had been set and he could not understand why he could not just be made category C to allow him to move on. Mr Samson said that he had nothing to live for, that he was going to stop working with the psychiatrist and indicated he might assault his offender supervisor if she came to see him again. He said that his offender supervisor had always wanted him to engage in group therapy, which he felt would endanger his life. The key worker told the investigator that he told wing staff about the conversation and then returned to his own wing.

Events of 22 July 2019

103. A Listener told us that he spoke to Mr Samson from 11.00am until the early afternoon. He said he had supported Mr Samson for the previous two years and described Mr Samson as a troubled man who felt let down by the system. He said that Mr Samson could be fine one minute, and completely different the next minute.
104. At around 3.00pm, an officer went to see Mr Samson after she was told that he wanted to speak to her. Mr Samson asked her to arrange a meeting with 11 named staff, including probation staff. He gave her a three-month time frame for the meeting to ensure everyone would be present. He said that if nothing was done, his plan was to hang himself in November on the second anniversary of arriving in Pentonville. He also said that he had not eaten for 12 days and that he had razor blades in his cell with which he planned to harm himself in two weeks' time. Mr Samson also asked her to help him write a Will. She said that she told an SO about the conversation.
105. At around 3.30pm, Mr Samson argued with other prisoners at the pool table, after which he returned to his cell. An officer asked Mr Samson if he was okay, and he said the other prisoners were arguing and he did not want to get involved. The officer then spoke to the other prisoners who said there had been a minor dispute about whose turn it was to play.
106. At around 4.00pm, a Listener returned from work to the wing and noticed people around Mr Samson's cell. He said Mr Samson was giving away his belongings and said that he was going to barricade his cell and kill himself. He said that he told two officers what Mr Samson had said. Another Listener gave similar evidence.
107. In an email at 4.02pm, the offender supervisor asked the key worker for further information about Mr Samson's threat to assault her. She then emailed others involved with Mr Samson to say that given his threat, and the report from the Millfields Unit, it was time to transfer him to a new prison. The strategic safety lead emailed to say that he agreed that Mr Samson should be transferred, that he believed Garth was an option, and he asked an SO to start the process. He added a comment about the need to keep Mr Samson safe, given that he had mentioned a fixed suicide plan.
108. At 5.00pm, Officer A noted in Mr Samson's ACCT that his mood had deteriorated quite quickly during the afternoon and that he had locked himself in his cell, saying he was in a bad place. He wrote that he had given Mr Samson information about Grendon and Warren Hill which he was reading. He wrote in a subsequent statement that he felt uneasy about Mr Samson, so he spoke to an SO about increasing the frequency of ACCT observations and decided to take his meal break on the landing in case he was needed. (We were unable to interview Officer A about the events of 22 July 2019 as he went on long term sick leave shortly after our investigation began.)
109. Officer B told us that he spoke to Mr Samson from around 5.00pm to 5.30pm. He said that Mr Samson was in a good mood and that he spoke about possibly going to Warren Hill and about his interest in music and cooking. After leaving Mr Samson's cell, he told Officer A that Mr Samson had had a bad afternoon but was now feeling better.

110. An SO told us that he spoke to both officers' concern about the frequency of ACCT observations but, based on what Officer B said, he did not consider that an increase of observations was needed.
111. At around 6.15pm, Officer C went to Mr Samson's cell, and he asked to see the wing SO. The officer told him that the prison was then in evening patrol state and the SO had finished duty. Mr Samson then gave the officer a sealed envelope on which he had written 'Will'. The officer asked Mr Samson for an explanation, and he said that he had had enough and asked to speak to a Listener.
112. Officer C unlocked a Listener so that he could speak to Mr Samson. She also radioed CM A, one of the two senior officers on duty.
113. The Listener spoke to Mr Samson for several minutes until a CM and an SO arrived and asked him to move away from the cell. He said that he could see that Mr Samson had barricaded his cell.
114. The CM told us that he and the SO arrived on the wing at around 6.45pm. He introduced himself to Mr Samson, spoke to him for a while and tried to persuade him to remove the barricade so that he could go into the cell to speak to him. Mr Samson refused to remove the barricade. The SO then took over talking to Mr Samson as the CM went to collect equipment, including an Allen key to gain entry to the cell.
115. The SO said that Mr Samson spoke about some of his personal history and was very pessimistic. She said that she tried to make the conversation more positive by talking about the future but Mr Samson said that he would be dead by the morning.
116. The Listener also spoke briefly to Mr Samson before Officer A began to speak to him at around 7.05pm. The officer said that when he came to the door, Mr Samson was pacing up and down in the cell but came to the cell door observation panel to talk to him. At about the same time, the CM began to adjust the door hinges. He adjusted the middle and bottom hinges with ease but found that the Allen key recess of the bolt securing the top hinge had rounded off so the Allen key would not engage. The CM said that Mr Samson realised what was happening and said that they were "not coming into the cell". He said that Mr Samson had already said that he would kill himself that evening, so he considered that staff had to gain entry. The officer told Mr Samson that it did not need to end that way and he tried to distract him by talking about two of the prisons Mr Samson was interested in, but Mr Samson said that he would never be allowed to transfer to those prisons or to hospital and said that it was too late.
117. Mr Samson had a length of torn bed sheet in his hand and he then sat on the window ledge and tied the ligature to the window bars and around his neck. Officer A told his colleagues what Mr Samson was doing. Mr Samson then let himself slide off the window ledge. The officer said that Mr Samson was hanging and the SO radioed a code blue alarm, indicating a life-threatening medical emergency.
118. The CM had still not been able to adjust the top bolt, so he radioed for a door enforcer ram and also radioed for the fire brigade to be called to assist in gaining entry to the cell. The CM collected further tools and was able to adjust the top hinge by hammering the Allen key into the bolt head recess.

119. Staff went into the cell around eight minutes after Mr Samson began to hang himself. One of the officers cut the ligature and Mr Samson was brought onto the landing where nurses were waiting to treat him.
120. Nurses checked Mr Samson for signs of breathing and a pulse, but there was none. They also found a second ligature around his neck which was hidden beneath his T-shirt with razor blades attached and which the nurses cut away. Nurses also found a foam ball, which was wet, and which Mr Samson had possibly held in his mouth. The nurses started cardiopulmonary resuscitation (CPR). Initially, they were unable to give a good supply of oxygen as the swelling to Mr Samson's neck made it difficult to insert an airway. However, they managed to insert an airway after around 20 minutes and were then able to give a good oxygen supply. Ambulance paramedics arrived at around 7.40pm and took charge of Mr Samson's care. The paramedics were able to establish a pulse and Mr Samson was taken to University College Hospital at around 9.00pm. Mr Samson remained in intensive care until he died on 23 August.

Contact with Mr Samson's family

121. Pentonville made enquiries to locate Mr Samson's family, but were told that all his siblings had been subject to confidential adoptions. After Mr Samson's death, a clinician in contact with one of Mr Samson's brothers made contact with Pentonville. His brother attended Mr Samson's funeral.
122. Pentonville contributed to the cost of Mr Samson's funeral in line with national instructions.

Support for prisoners and staff

123. The strategic safety lead debriefed the staff involved in the response when Mr Samson was discovered. The staff care team also offered support.
124. The prison posted notices informing other prisoners of Mr Samson'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 Samson's death.

Post-mortem report

125. Mr Samson's post-mortem report gave his cause of death as cerebral hypoxia-ischaemia due to suspension, with a secondary cause of death as pneumonia.

Findings

Management of risk of suicide and self-harm

126. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. Mr Samson was supported under ACCT procedures throughout much of his time at Pentonville, including when he harmed himself on 22 July. ACCT case reviews were generally multidisciplinary and made up of staff who knew Mr Samson well. Generally, Mr Samson received good support from staff, including from his key worker.
127. However, while there is much that was positive about Mr Samson's general management, we have concerns about aspects of his ACCT management.

Caremap

128. PSI 64/2011 instructed that, in the version of ACCT used in 2019, a caremap had to be completed at the first case review for all prisoners subject to ACCT monitoring. It said that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview and at later case reviews. (In a revision to PSI 64/2011, issued in July 2021, the caremap was replaced by a support plan.)
129. We consider that there were inadequacies in the use of the final caremap in addressing Mr Samson's risk. No caremap actions were made following his first three ACCT case reviews. His sentence plan was clearly a considerable issue for Mr Samson and caremap actions might have been used to ensure that this was monitored and discussed at future case reviews. There was also no caremap action made to address Mr Samson's food refusal and apparent weight loss.
130. On several occasions, Mr Samson showed staff that he had accumulated razors with which he threatened to harm himself, including the occasion when he barricaded himself in his cell.
131. In April 2019, the Prison Service issued a safety briefing about the management of razors in prisons. This requires that access to razors and other sharp items should be discussed at ACCT case reviews and the outcome reflected in the caremap for all prisoners subject to ACCT monitoring. While we recognise the difficulties in managing access to razors for prisoners on normal location, there is no discussion in Mr Samson's case reviews about how he had managed to collect razors.

Level of risk

132. At his final ACCT case review, on 19 July, Mr Samson was told that the Millfields Unit had not accepted his return. His next case review was set for 25 July, to allow time for a psychiatrist and his offender supervisor to speak with him, which was not included on the caremap. A substantial team of experienced staff were involved in Mr Samson's care and all would have realised his disappointment at hearing the outcome of the referral. Mr Samson made frequent threats about taking his life, which included very specific threats about taking his life if he did not return to the

Millfields Unit. We consider that Mr Samson's support team should have combined to give greater thought to how and when to disclose the news to Mr Samson and to the provision of additional support in the following days: this could have included making prior arrangements for dates and times for key people to speak with him. Given Mr Samson's threats, more thought should also have been given to increasing his level of risk and frequency of ACCT observations and conversations.

133. During the afternoon of on 22 July, there were clear signs of an escalation of risk: Mr Samson asked an officer to help him write his Will, he spoke about using razors to harm himself and he said he had not eaten for 12 days. He told another prisoner that he was going to barricade himself in his cell. Officer A noted in Mr Samson's ACCT that his mood had deteriorated quite quickly during the afternoon. The SO did not speak to Mr Samson himself but, after speaking to Officer B at about 5.30pm, he did not consider that he needed to adjust the level of observations.
134. Guidance in the ACCT document is that risk is high when a prisoner has frequent suicidal ideas that are not easily dismissed, there is a specific plan with likely access to lethal methods and the situation experienced causes unbearable pain.
135. While Mr Samson clearly received a great deal of support from staff through that afternoon, we consider that the SO should have spoken directly to him and considered increasing his level of risk and frequency of observations. We make the following recommendations:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:

- **support actions are set that are specific, meaningful and identify all of the issues identified at assessment interviews and case reviews, including ensuring that appropriate support is provided when difficult news is given to a prisoner at risk of suicide and self-harm;**
- **prisoners' access to razors is managed in line with national instructions; and**
- **case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.**

Moving Mr Samson on from Pentonville

136. Mr Samson was transferred to Pentonville in November 2017, as it was the prison local to the Millfields Unit. In their discharge summary, Millfields Unit staff explained that Mr Samson had made no progress with his treatment targets, that he continued to breach boundaries, and that the Unit would support Pentonville in Mr Samson's onward referral to a more suitable prison. Mr Samson was still at Pentonville 20 months later when he committed the act of significant self-harm that ultimately resulted in his death.
137. No action was taken by Pentonville to transfer Mr Samson during the first several months as the prison wanted him to stabilise and the ESS team were trying to support him with this goal. Unfortunately, there appears to be no clear point when

Mr Samson properly stabilised: he was clearly very frustrated with his situation and often reacted by harming himself. In addition, he was found at times to have used illicit substances and was also found in possession of a mobile phone with which he attempted to contact his co-defendant.

138. When the offender supervisor began to speak with Mr Samson about a move to a suitable prison for sentence progression, he resisted suggestions that involved group work as he said that he feared for his safety when speaking about the circumstances of his offence. Instead, Mr Samson believed he could go to a category C prison and receive one-to-one support. There are also indications that Mr Samson thought that he was progressing through his sentence solely on the basis of time served, as he seemed to believe that he was potentially close to becoming a category D prisoner and that there was a possibility that he might achieve parole in the near future. In April 2019, there was a further pause in efforts to transfer Mr Samson when he persuaded his offender supervisor to try to refer him back to the Millfields Unit.
139. For Mr Samson to make true progress through his sentence, it was essential for him to engage and deal with the significant issues surrounding his offence. However, he either failed, or refused, to understand this and when he was told that he would not be returning to the Millfields Unit, this was a pivotal moment for him. It is unclear how or why his offender supervisor was unable to impress upon Mr Samson what he needed to do to progress, but this was clearly the key issue. We note that their relationship became very strained, and Mr Samson also made some veiled threats towards her: possibly because he did not want to hear what she was telling him or perhaps due to clash of personality. We cannot say what alternative steps might have made a difference, but we do not consider that sufficient thought was given in considering how to resolve the impasse, such as transferring Mr Samson to a different offender supervisor. She said that she and her manager did discuss this option, but we are unclear why Mr Samson was not transferred given the clear breakdown in the relationship. We make the following recommendation:

The Governor should ensure that prison offender managers (previously known as offender supervisors) are given appropriate support where needed, including that:

- **prison offender managers are accompanied by a senior colleague, where appropriate, in reiterating difficult messages to prisoners; and**
- **prisoners are re-allocated to a new prison offender manager when the relationship with the existing offender supervisor has broken down.**

Attempted return to the Millfields Unit

140. On 26 April 2019, Mr Samson asked his offender supervisor about returning to the Millfields Unit and she agreed to send a referral. Following his assessment, a member of the Unit advised Pentonville that referral to a prison PIPE unit seemed the appropriate pathway. Mr Samson was told of this outcome on 19 July, just days before his significant act of self-harm. We understand that prison referrals to the Millfields Unit would ordinarily come from the prison healthcare team following an assessment by the prison psychiatrist. In Mr Samson's case, the referral came direct from the offender supervisor without apparent consultation with the mental

health inreach team (although she did inform a psychologist involved in Mr Samson support).

141. We cannot say what might have happened had the offender supervisor asked Pentonville's mental health inreach team to consider Mr Samson's suitability for referral to the Millfields Unit, although there is no indication of any significant change in his behaviour or mental health state since his discharge from the Millfields Unit in November 2017. We cannot say how Mr Samson might have responded had he been told in April that there was no basis for a further referral to the Millfields Unit. However, we do not consider that it was helpful for him to spend the following three months waiting and hoping for an outcome that always seemed destined to be a refusal to re-admit him. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff at Pentonville understand that referrals to secure mental health units should only be made through the prison's mental health Inreach team.

Management of Mr Samson's food refusal

142. Chapter 10 of PSI 64/2011, *Management of prisoners who refuse food and/or fluids and medical treatment*, says that food and fluid refusal is not considered in law to be a form of self-harm, but that the ACCT process may provide a useful way of recording the care offered and facilitate information sharing and that many prisons put in place a food refusal log. It instructs that every effort must be made to try to find out why the prisoner is refusing food and/or fluids and address the reasons for their refusal. PSI 64/2011 also refers to Department of Health guidance on practical and clinical management of individuals during and following refusal to eat. This guidance states that it is critical that a thorough assessment of a person's mental capacity and nutritional status is undertaken immediately and there should be regular reassessments of the person's physical and mental state.
143. The psychologist noted on 13 June that Mr Samson appeared to have lost a lot of weight and she referred him to the primary care team. On 15 July, Mr Samson refused his evening meal, and he told an officer that he would no longer take food until he was transferred. On 19 July, Mr Samson said at an ACCT case review that he had started food refusal as a course of self-harm. On 22 July, he said that he had not eaten for 12 days.
144. Despite all of these references, prison and healthcare staff did not take any specific action. They did not start a food refusal log or create a food and fluid care plan to monitor Mr Samson's nutritional needs. His food refusal was not included as an issue on his caremap. We note that Mr Samson's weight at post-mortem was 42kg, which is 14.6kg less than when he was last weighed in April 2018. Although we cannot speculate what his weight had been on the day that he harmed himself and was sent to hospital, there is considerable evidence that he had stopped eating properly and had lost weight.
145. The clinical reviewers noted that Mr Samson's records contain reference to periods of time when he was not eating, but they note the absence of records of his weight on an ongoing basis and that there are no reassessments of his nutritional needs following the initial assessments after Mr Samson's arrival in Pentonville. We recommend that:

The Governor and Head of Healthcare should ensure that staff manage a prisoner who is refusing food in line with national guidelines.

Events of 22 July 2019

The decision to enter Mr Samson's cell

146. Mr Samson had barricaded himself in his cell for ten days in the beginning of June, until staff eventually persuaded him to remove the barricade and to come out of his cell for an ACCT case review.
147. However, in the late afternoon of 22 July, CM A decided to gain entry into Mr Samson's cell without delay. Mr Samson said that he would kill himself if staff came into the cell, but the CM's assessment was that staff needed to enter the cell as Mr Samson had also said that he intended to take his life that evening.
148. We appreciate that CM A found himself in a very difficult position that afternoon. He did not know Mr Samson, and most of the staff, including those who best knew Mr Samson, would have left the prison by that time. However, Mr Samson had not started to harm himself at the point that CM A arrived on the wing and Officer A, whom Mr Samson appeared to like and trust, was on duty. In addition, we note that Pentonville's Contingency Plan on dealing with barricades instructs that the orderly officer should take instruction from the duty governor. We believe that CM A should have spent more time in evaluating the situation and in considering alternative options. For instance, he could have asked the officer and prisoner Listeners to speak with Mr Samson while he took advice from the duty Governor, and he might have considered the use of trained negotiators. He might also have considered placing Mr Samson under constant supervision through the night.

Difficulty in entering the cell

149. When CM A decided to enter the cell, the barricade meant that he had to use the anti-barricade Allen key to remove the cell door. When attempting to remove the top bolt, he found that the Allen key recess had rounded off, which took an additional eight minutes to remove. An officer told the investigator that he was in charge of maintenance and facilities at Pentonville and explained that full checks on the door hinge bolts were made every six months, which included unscrewing and re-screwing each bolt. He also understood that a visual check of the bolts formed part of the standard daily cell fabric checks made by officers, which CM A confirmed to be the case. We do not know how visible the existing damage was to the final bolt, which would of course have been further damaged when it was removed that day. We make the following recommendations:

The Governor should ensure that staff inform the duty governor when a prisoner has barricaded himself in his cell and that staff consider all options, including use of trained negotiators, when dealing with prisoners who are threatening suicide or significant self-harm.

The Governor should share a copy of this report with CM A and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Governor should ensure that officers check the condition of door hinge securing bolts when making their daily cell fabric checks.

Clinical care

150. The clinical reviewers noted that Mr Samson did not have a severe or enduring mental illness but had antisocial and borderline personality disorders and a complex post-traumatic stress disorder. The reviewers noted that the healthcare provisions at Pentonville were not commissioned to provide the sustained therapeutic intervention required for people diagnosed with such personality disorders. However, the reviewers noted that the ESS team kept Mr Samson on their caseload for a considerable time and continued to support him informally, even after he had been discharged from their caseload. They found that this was an example of good practice and above the standard expectation of the service. The clinical reviewers also noted the considerable support Mr Samson received from a worker from the Building Futures team and individual psychology support from the psychologist.

Inquest

151. An inquest into Mr Samson's death that concluded on 11 December 2023 found that his medical cause of death was cerebral hypoxia ischaemia following suspension and pneumonia. The inquest jury concluded that his death was from misadventure exacerbated by the mechanical failure of the cell door hinge bolt.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100