Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Peter Campbell, a prisoner at HMP Pentonville, on 8 October 2024

## A report by the Prisons and Probation Ombudsman

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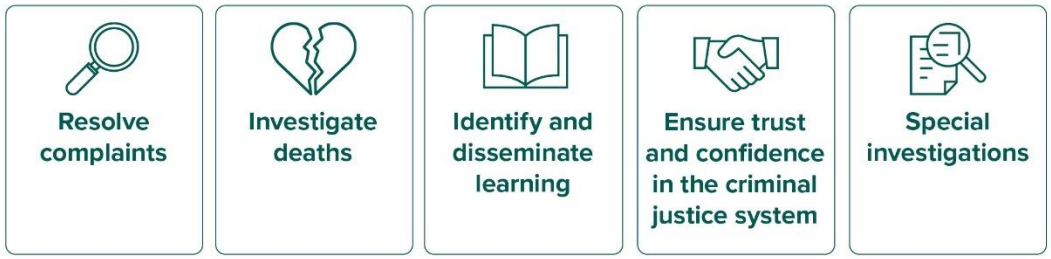
## OUR VISION

**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

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Peter Campbell died in hospital of pneumonia and ischaemic hypoxic brain injury caused by a cardiac arrest following alleged drug use on 8 October 2024, having been found unresponsive in his cell on 3 October at HMP Pentonville. He was 36 years old. I offer my condolences to Mr Campbell's family and friends.

Mr Campbell had a history of mental illness and substance misuse, and both were features of his last period in prison. Although Mr Campbell received frequent and considered care from his mental health in-reach worker, opportunities were missed across the board to help Mr Campbell, particularly to act on some intelligence reports and safeguarding referrals.

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 2025**

# Contents

# Summary

## Events

1. On 9 March, Mr Peter Campbell was remanded to HMP Wormwood Scrubs charged with burglary. On 9 April, he transferred to HMP Pentonville.

2. Mr Campbell had a history of poor mental health, including a diagnosis of schizophrenia, and drug misuse. He also had a history of attempted suicide and self-harm.

3. On arrival at Pentonville, he was assessed by the mental health team and taken onto their caseload. His in-reach key worker saw him frequently and kept detailed records of their interactions. Mr Campbell did not wish to work with the prison's psychosocial substance misuse team, Phoenix Futures.

4. On 18 April, staff started suicide and self-harm prevention measures (known as ACCT), after Mr Campbell started eating his own faeces. A few days later, Mr Campbell was found under the influence of substances and his involvement with psychoactive substances (PS) (both using substances and moving them around the prison) continued. Staff submitted several intelligence reports, but Mr Campbell's cell was only searched once.

5. In June, staff closed Mr Campbell's ACCT because he seemed more stable.

6. By July, Mr Campbell's PS use had increased again and his behaviour deteriorated.

7. On 18 and 19 September, staff referred Mr Campbell to the safeguarding team because they were concerned about his presentation, PS addiction and that he was possibly being used by other prisoners to test PS. The safeguarding team did not meet with Mr Campbell as they should have done.

8. Also on 19 September, a consultant psychiatrist assessed Mr Campbell, but did not assess him as acutely unwell enough for a hospital transfer.

9. On 3 October, an officer found Mr Campbell unresponsive in his cell having apparently taken PS. The officer radioed a medical emergency code and custodial and healthcare staff attended. Paramedics arrived and took Mr Campbell to hospital, but he did not recover.

10. On 8 October, Mr Campbell died.

11. The post-mortem report noted Mr Campbell's cause of death to be pneumonia and ischaemic hypoxic brain injury caused by a cardiac arrest following alleged use of synthetic cannabis.

## Findings

12. Mr Campbell had a history of mental illness and substance misuse, and both were features of his last period in prison custody. Mr Campbell received frequent and considered care from his mental health in-reach worker, but staff missed

opportunities to help Mr Campbell further, particularly to act on some intelligence reports and safeguarding referrals.

13. Mr Campbell was able to access illicit drugs with apparent ease at Pentonville. There was intelligence to suggest that prisoners, including Mr Campbell, were distributing and using illicit substances in the prison and that he was being used as a guinea pig to test new PS that came into prison. While Mr Campbell was offered appropriate support from the substance misuse team, he did not always fully engage.

14. Pentonville's interim drug strategy is clear and addresses the current trends and access routes for PS into the prison. However, staff did not act upon all of the intelligence which indicated Mr Campbell was involved in the illicit drug culture at the prison and staff completed only one intelligence-led search of his cell.

15. The clinical reviewer concluded that the healthcare Mr Campbell received at Pentonville was equivalent to what he could have expected to receive in the community.

## Recommendations

- The Governor should ensure that ACCT care plan actions are quality assured regularly to satisfy himself that all actions have been fully completed.

- The Head of Safety should ensure members of the team keep SIM meeting minutes and that, as far as is reasonably possible, there is adequate cover when staff are on leave to deal with safeguarding referrals.

# The Investigation Process

16. HMPPS notified us of Mr Campbell's death on 8 October 2024.

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

18. The investigator visited Pentonville on 14 October. She obtained copies of relevant extracts from Mr Campbell's prison and medical records.

19. The investigator interviewed ten members of staff at Pentonville and by video conferencing between December 2024 and January 2025.

20. NHS England commissioned a clinical reviewer to review Mr Campbell's clinical care at the prison. The investigator and the clinical reviewer carried out joint interviews.

21. 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.

22. The Ombudsman's office contacted Mr Campbell's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Campbell's family wanted to know if Mr Campbell's mental health was appropriately cared for and if his suicide risk was monitored. We have answered these questions in the clinical review and in our report.

23. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.

24. We also shared the report with Mr Campbell's family. They did not make any comments.

# Background Information

## HMP Pentonville

25. HMP Pentonville is a local prison in London that primarily serves the courts of north and east London. Practice Plus Group, in partnership with Barnet, Enfield and Haringey Mental Health Trust, provides healthcare services.

## HM Inspectorate of Prisons

26. The most recent full inspection of HMP Pentonville was in July 2022. Inspectors highlighted eight priority concerns, including that the prison was severely overcrowded and could not safely or decently care for the number of prisoners it was required to hold.

27. HMIP returned to Pentonville in April 2023 to conduct an independent review of progress. Inspectors identified reasonable progress on five of their key concerns but were disappointed to find that the prison was even more overcrowded than in 2022. Improvements had been made to support prisoners in the early days of custody and most of the shortfalls in primary care services had been addressed. Although staffing levels had improved, there was still pressure on the daily management of the regime and time out of cell was limited. The rate of self-harm at Pentonville had continued to reduce and was the lowest among all reception prisons.

## Independent Monitoring Board

28. 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 31 March 2023, the IMB reported the key work scheme was barely operating due to staff shortages and the priority of security operations. Regular safety meetings were held which was a significant improvement and were attended by prisoner representatives for the first time since COVID-19. Improved analysis of safety data was available to prison management and to the IMB. Another positive development was a fortnightly Safety Intervention Meeting.

## Previous deaths at HMP Pentonville

29. Mr Campbell was the sixth prisoner to die at Pentonville since October 2021. Of the previous deaths, two were self-inflicted and three were from natural causes. Up to the end of April 2025, there had been four deaths at Pentonville since Mr Campbell’s death. Three were self-inflicted and one was natural causes.

## Assessment, Care in Custody and Teamwork

30. Assessment Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

31. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

## Psychoactive Substances (PS)

32. The term psychoactive substances is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

33. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

# Key Events

34. On 9 March 2024, Mr Peter Campbell was remanded to HMP Wormwood Scrubs charged with burglary. On 9 April, he transferred to HMP Pentonville.

35. Mr Campbell had a history of schizophrenia and depression. He had previously been sectioned under the Mental Health Act several times and received treatment in a psychiatric hospital. He received medication for his conditions.

36. Nurse A carried out a reception health screen. Mr Campbell said he had schizophrenia and depression for which he received medication, but he could not remember what. He said he used cannabis but not alcohol. The nurse referred Mr Campbell to the mental health team for review and to clarify his medication needs.

37. On 10 April, Ms A carried out a medication reconciliation and noted Mr Campbell had previously been prescribed Flupentixol (an antipsychotic – 400mg every four weeks) administered by injection by his Community Mental Health Team. Ms A let the mental health team know.

38. That day, Nurse B carried out a mental health assessment. She noted Mr Campbell had a number of risk factors including that he ate his own faeces in response to auditory command hallucinations and he was potentially vulnerable to bullying. (These concerns were discussed with one of the prison doctors and it was agreed a number of welfare checks should be undertaken over the coming weekend to ensure his safety.) Nurse B noted that Mr Campbell could also be at high risk of deteriorating mental/physical health due to ongoing drug use, but he had declined support from Phoenix Futures, the psychosocial substance misuse service.

39. On 16 April, the mental health team reviewed Mr Campbell's case and he was added to their case load. A member of the Phoenix Futures team, Ms B, noted that Mr Campbell had completed their induction but said he did not want to work with their service. He said he did not have a problem with substances, but she gave him harm minimisation advice and was content he knew how to contact them if he changed his mind.

40. On 17 April, Nurse B reviewed Mr Campbell's care plan. Mr Campbell asked her when he would be admitted to a psychiatric hospital and said he did not think he could cope in prison. She told him more information was needed and a psychiatrist would need to assess him. She noted he and his cell were clean and that she had offered him distraction materials which he had declined. He did not want her to refer him to the Wellbeing Centre or for education but he said he would let her know when he was ready.

## ACCT 18 April to 5 June 2024

41. On 18 April, Mr Campbell told Officer A he had been eating his own faeces as he wanted to harm himself and end his life. Officer A started ACCT procedures and took Mr Campbell to see Nurse C. The ACCT concern form was left blank.

42. Supervising Officer (SO) A completed the Immediate Action Plan and set the frequency of checks at one an hour, with a requirement for staff to record three daily

conversations with Mr Campbell. SO A's record does not say whether staff had established why Mr Campbell was self-harming, but she noted he said he recreationally used drugs and wanted to call his family and that their phone numbers had been cleared. SO A did not comment on whether Mr Campbell had any phone credit at that point, but Mr Campbell went on to make calls while he was at Pentonville.

43. On 19 April, SO B carried out the ACCT assessment at the same time SO A chaired Mr Campbell's ACCT review. Mr A (from the healthcare team) attended. Mr Campbell said he ate faeces as a way to self-harm and had last done this two days previously. He said he had been sectioned several times, tried to jump off a cliff once and had been on lots of medication (including by depot injection) in the community. He said he had been hearing voices since his mother died 20 years earlier.

44. Mr A said he would talk to a colleague about Mr Campbell's medication and that the healthcare team were looking into transferring him to a secure hospital. Mr Campbell said his father was no longer picking up his calls and his stepmother did not want to speak to him but one of his brothers wanted to visit him. He was told how to arrange visits. Mr Campbell also talked about a complex relationship with his wife and children.

45. Mr Campbell said he had used crack and cocaine prior to being remanded to prison, but he was still not interested in working with Phoenix Futures. The review also covered his court case and one of the attendees said he would get him a number for his solicitor. Attendees checked he knew how to contact Listeners (prisoners trained by the Samaritans to provide a listening service) and Samaritans.

46. Care plan actions included that Mr Campbell was to book visits for his brother and the mental health team should see Mr Campbell – the latter action was assigned to Mr A. Another action was for Mr Campbell to move off the wing so he could attend the gym and SO A was assigned to this. SO B had an action to contact an organisation who could help Mr Campbell contact his children. ACCT review attendees agreed Mr Campbell's ACCT would remain open on two hourly observations with three daily conversations until his next review on 29 April.

47. On 23 April, staff found Mr Campbell unresponsive in his cell possibly as a result of PS. A nurse reviewed him and noted no further clinical concerns.

48. On 29 April, SO C held an ACCT review. Mr Campbell said he was in crisis and had consumed his faeces that day. He believed he should be in hospital and complained about not having a TV and kettle in his cell, then later said he had sold them. He also said he had recently used drugs on the wing. SO C contacted the mental health in-reach team who said that they would carry out a mood review on the 2 May. Mr Campbell was not interested in any purposeful activity or any input from the substance misuse service. An action was added to the care plan for him to complete a Basic Skills Assessment (BSA) so he could do activities. Mr Campbell said that he would continue to eat his own waste. SO C noted the ACCT was to remain open with one observation every three hours, and one morning and one afternoon conversation.

49. On 2 May, Mr Campbell told wing staff he had swallowed a vape battery. Healthcare staff took observations and monitored him for two days.

50. On 16 May, SO D was due to hold an ACCT review with Mr Campbell and healthcare staff but she suspected Mr Campbell was under the influence of PS and rescheduled it to the following day. She increased ACCT observations to twice an hour. Staff seized drug paraphernalia from Mr Campbell's cell and submitted an intelligence report. Security staff concluded that no further action was needed at that time.

51. The next day, Mr Campbell was found under the influence of drugs again and staff submitted another intelligence report. Healthcare staff attended and deemed no treatment was necessary. The security team completed an intelligence assessment and concluded that it was a likely a named prisoner was supplying drugs to other prisoners including Mr Campbell.

52. On 18 May, SO E held an ACCT review. Officer B from the wing also attended. Mr Campbell said he had no thoughts of suicide or self-harm but said that he had swallowed a vape and no one was taking him seriously. Mr Campbell said that he had been sectioned before and wanted to go to a psychiatric facility. SO E maintained half-hourly observations.

53. On 19 May, a member of staff submitted an intelligence report stating Mr Campbell had been seen visiting a known PS user's cell. The security assessment concluded this was 'building block' intelligence, meaning it was something that might contribute to a bigger picture.

54. On 20 May, SO F held an ACCT review and SO D attended. Mr Campbell seemed much better and was fully coherent. He said he liked to smoke PS when things got on top of him so he could feel 'nothing'. SO F discussed the dangers of PS and ways he could better himself. Mr Campbell said he was interested in education and SO F noted he was going to take that forward for Mr Campbell. Mr Campbell expressed a wish to repair his relationship with his children and said that he would give anything a try to help with that. SO F reduced observations to hourly (although his note said he was maintaining them at two an hour) with a morning and afternoon conversation.

55. On 20 May, Mr Campbell spoke to Mr B from Phoenix Futures. He said he needed help addressing his substance use. Mr B gave harm reduction advice and noted Mr Campbell needed an assessment.

56. On 22 May, a member of staff submitted an intelligence report following information from a prisoner to say that approximately three weeks previously, Mr Campbell had held another prisoner at knifepoint and an improvised knife had been found in his cell. The intelligence assessment referenced 'mash' (we do not know what this term referred to in this context but it can mean drugs or weapons) and a zanco (a small phone) and implied that the argument had probably been about the phone. The suspected supplier's cell cited on 19 May was searched on 22 May in relation to that incident, and Mr Campbell's was searched on 22 May also – presumably as a result of cumulative incidents. Staff did not recover anything of note from either cell. A member of the Security team told us that the individuals were personally searched too, but nothing was found.

57. On 23 May, Mr C from Phoenix Futures, tried to carry out a substance misuse assessment but Mr Campbell would not engage.

58. On 27 May, SO F held an ACCT review. Mr Campbell said he had been feeling quite well and had been taking much less PS than he usually did. He seemed happy about it and said he could think more clearly. SO F asked Mr Campbell if he still wanted to enrol on an English education programme, and he said he was very keen and thought it would really benefit him. SO F said he had already spoken to the education department, but they were yet to action it. Mr Campbell said he would not completely stop using PS at that time but was determined to keep lowering the amounts. SO F explained that he understood and that using the drug less was a step closer to becoming clean. SO F decided to keep Mr Campbell's ACCT open but reduced observations to once every three hours with one morning and one afternoon conversation.

59. On 4 June, Mr Campbell completed a psychosocial substance misuse session with Mr C and was given some workbooks to complete.

60. On 5 June, SO F held an ACCT review and another officer attended. Mr Campbell said he had halved his PS use and had no thoughts of suicide or self-harm. SO F reminded him he could speak to healthcare staff if he needed any help related to substance misuse. He said he was looking forward to starting his education course. SO F closed the ACCT.

61. On 13 June, SO F held a post-closure review and the ACCT remained closed as there were no concerns. In the post-closure form section where the SO and prisoner should review the actions detailed in the support plan, SO F noted that Mr Campbell no longer ate his own waste as a method of self-harm and he had chosen not to have a TV in his cell as it was more peaceful without it. He did not make any reference to the other matters raised in the ACCT support plan.

62. On 19 July, a member of staff submitted an intelligence report saying that Mr Campbell was suspected, along with other prisoners, of moving drugs around the prison. The intelligence assessment concluded that it was likely the prisoners were using PS but not what action would be taken.

63. On 6 August, staff submitted an intelligence report to say Mr Campbell had been found under the influence of drugs in another prisoner's cell. The assessment said the information would be copied to another named prison (presumably because the other prisoner had moved there).

64. On 14 August, Mr Campbell was involved in a fight although the reasons for this were not clear as he would not give staff any details. Staff submitted an intelligence report and the analyst concluded it was building block intelligence and no assessment was necessary at that time.

65. On 26 August, Mr Campbell told Officer C he had been assaulted. He would not talk about it or give any names but he provided the prisoners' cell numbers. A member of staff submitted an intelligence report and the analyst concluded it was building block intelligence and an assessment was not required at that time.

66. On 17 and 18 September, staff noted that Mr Campbell seemed under the influence of drugs. They called the healthcare unit and submitted an intelligence report.

67. Also on 18 September, Officer D referred Mr Campbell to the safeguarding team because Mr Campbell's personal hygiene was poor, he did not socialise much, and he seemed to be struggling with a PS addiction. Officer D felt Mr Campbell would benefit from some extra support.

68. On 19 September, Mr Campbell had an in-person review with Consultant Psychiatrist Dr A. She concluded that although he had schizophrenia, he was not acutely unwell, so a hospital transfer was not appropriate.

69. That day, Nurse D also completed a safeguarding referral for Mr Campbell. This outlined a concern that he was being used as a 'guinea pig' to test the potency of batches of PS arriving in the prison and that he was vulnerable because he had mental health issues.

70. On 23 September, the safety team held a Safety Intervention Meeting where safeguarding referrals were discussed. No meeting minutes were taken, but Mr Campbell should have been discussed and an action set for a member of the safety team to interview him. There is no evidence this happened. As no one raised an action (if he was discussed), he was not discussed at following weeks' meetings.

71. On 30 September, Mr C saw Mr Campbell for a psychosocial session but Mr Campbell said he was busy cleaning a cell. On 1 October, Ms C saw Mr Campbell for some harm reduction work. He seemed drowsy but denied he had taken substances. He denied any thoughts of suicide or self-harm and Ms C gave him information about the dangers of PS use.

72. That day, Mr Campbell had his last review with his mental health in reach team keyworker Nurse B before his death. (He had over 20 sessions in total). She was checking in on him because the day before he had told her he was due in court on 1 October and was optimistic about being released soon. (His court date was not, in fact, until 7 October.) Nurse B had no concerns.

## Events of 3 October

73. The following account has been taken from CCTV footage and staff and prisoner statements.

74. On 3 October, Officer E noted in Mr Campbell's record that he had failed a mandatory drug test for PS and been put on report. (The test had been taken on 26 September.) Officer E did not see Mr Campbell face to face.

75. At 3.30pm, Mr Campbell refused to collect his medication and told Officer F that he wanted to stay in his cell. She informed the pharmacist.

76. At 3.48pm, a prisoner put something under Mr Campbell and his cellmate's door and another prisoner briefly visited them shortly after.

77. At approximately 4:55pm, Officer G went to speak to Mr Campbell about a property matter. She could see Mr Campbell's legs positioned as if he were sat on the bunk and his cellmate was stood up in the cell. She felt something was wrong and went

into the cell calling for another officer behind her to come with her. When she opened the door, Mr Campbell's cellmate left immediately.

78. Mr Campbell was sitting on the bottom bunk, leaning to his right side with saliva dripping out of his mouth. Officer G could smell PS and radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties) at 4.55pm. Staff in the control room called an ambulance. Officer G put Mr Campbell in the recovery position and Custodial Manager (CM) A, CM B and SO D attended. When they realised that Mr Campbell was unconscious and not breathing, the officers commenced cardiopulmonary resuscitation.

79. At 4.58pm, Nurse F and Nurse G attended and applied a defibrillator and delivered oxygen to Mr Campbell.

80. At 5:07pm, paramedics arrived and took over resuscitation efforts. They restored Mr Campbell's pulse using the automatic defibrillator and stabilised him for transport to hospital at approximately 6.00pm. Mr Campbell remained unconscious.

81. Staff did not apply any restraints while Mr Campbell was transferred or during his stay in hospital.

82. Mr Campbell did not recover and on 8 October, at 5.35pm, he died.

## Contact with Mr Campbell's family

83. On 3 October, the prison appointed CM C as the family liaison officer. He attempted to contact Mr Campbell's father several times to let him know his son was in hospital but did not manage to speak to him until 7 October.

84. Mr Campbell's father said he did not want contact from the prison, but after his death the prison wrote to him and offered a contribution to funeral expenses in line with national policy.

## Support for prisoners and staff

85. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support).

86. In line with this approach the Samaritans attended Pentonville and supported Listeners completing their duties.

87. After Mr Campbell's death, the duty 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.

88. The prison posted notices informing other prisoners of Mr Campbell'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 Campbell's death.

## Post-mortem report

89. The post-mortem report gave Mr Campbell's cause of death as pneumonia and ischaemic hypoxic brain injury caused by a cardiac arrest following alleged use of synthetic cannabis. No toxicology tests were carried out.

## Inquest

90. The Coroner's inquest, held on 10 March 2026, determined the medical cause of death to be drug related.

91. The jury's narrative verdict concluded that there was a failure to prevent drugs from entering the prison, there was a failure from drug and alcohol services to provide a meaningful interaction with Mr Campbell following a serious drug related incident on 18 September 2024, for which he required resuscitation, there were reports that Mr Campbell was likely testing new batches of spice within the prison, and a failure to act on this intelligence. The impact of these failures on Mr Campbell's death was considered unclear.

92. On 11 March 206, the Coroner issued a Prevention of Future Deaths notice.

# Findings

## Assessment of Mr Campbell's risk of suicide and self-harm

93. We have no reason to believe Mr Campbell's fatal PS use was a result of attempted suicide or self-harm. However, effective ACCT management can highlight issues which may cause an individual to use substances and seek to address those as part of a meaningful support plan.

94. Mr Campbell was subject to ACCT procedures while at Pentonville. His ACCT case reviews were held when they should have been, attendance was sometimes multi-disciplinary and detailed accounts of the reviews were written up. However, the investigator found that at the post-closure review on 13 June, the discussion about the support plan and what had changed since the ACCT had opened did not seem to cover the matters in the support plan. SO F was content to close the ACCT because Mr Campbell was no longer eating his own waste as a means to self-harm and he had decided to not have a TV in his room. Although the records suggest Mr Campbell did engage to some degree with education and considered seeing family, SO F did not reference how these actions had progressed specifically and it is unclear what happened with regards to him contacting his children. We make the following recommendation:

    **The Governor should ensure that ACCT care plan actions are regularly quality assured to satisfy himself that all actions have been fully completed.**

## Drug strategy at Pentonville

95. Mr Campbell was regularly found under the influence of substances at Pentonville and was apparently able to obtain them with ease. We have considered the effectiveness of the prison's approach to reducing the availability of drugs.

96. The investigator interviewed Mr D, the head of Pentonville's drug strategy. He took up post in May 2024 and said he was advised to wait for the national drug strategy to be published before tailoring it for a local approach and producing a drug strategy document for Pentonville.

97. Mr D said that he focused on liaising with the regional drug strategy lead and set up monthly drug strategy meetings at Pentonville which other heads of function, healthcare staff and Phoenix Futures attend. More recently, Mr D has invited prisoners too. In common with other strategic approaches, Mr D's emphasis has been on restricting supply, reducing demand, and also building recovery.

98. The monthly drug strategy meeting discusses data collected on drug finds (and specifically PS), locations of finds, scan results, under the influence numbers, healthcare data on emergency codes, drug testing results, voluntary drug testing, Phoenix Futures information and pharmacy statistics on abused medications. Data collected for a drug strategy meeting showed 48 code blues called in September 2024 for prisoners under the influence and 23 of these were suspected to relate to PS.

99. Mr D said that the forensic service they used to provide drug test results could not keep up with demand and the turnaround time for test results could be as much as 70-80 days which impacted on the prison's ability to take an intelligence led approach to substance misuse. The investigator asked Mr D for an update on this situation. He said that shortly after the PPO interview, the national key forensic testing was paused and an interim urgent request system put in place instead, approved by the regional drug strategy lead. Key forensic testing has now restarted with the head of security taking the lead on requests. However, it is not clear to us if this has improved timeliness.

100. If a rapid response to an issue is required (for example a sharp increase in code blues related to a batch of PS) the matter is discussed at the morning meeting or sometimes over email and a response formulated. Mr D said Practice Plus Group have been good at relaying nurses' concerns and thoughts about drug use and that, recently, the prison decided to hold a 'wing surgery' in response to PPG led information. Phoenix Futures and healthcare staff took part and gave prisoners harm minimisation advice and education regarding the dangers of PS. Drug amnesties have also been held. After Mr Campbell's death, an amnesty was run on his wing specifically in response to his death.

101. Drug testing is carried out at Pentonville including random tests, suspicion-based testing (as a result of intelligence tests) and area based (risk-based) testing (because certain parts of the prison may be more susceptible to drug activity). Frequent testing, which had been used in the past for serial abusers, had been stopped but there are plans to reintroduce it as an alternative to disciplinary action. Voluntary testing takes place twice a month on the Incentivised Substance Free Living wing.

102. Searches can be carried out in response to intelligence and will be assigned a priority which indicates how quickly the search should be done. Enhanced gate security and other measures had led to higher numbers of staff being searched and suspensions and this seemed to have had a knock-on effect in the form of more throwovers (items being thrown over the perimeter wall rather than brought in through staff or visits).

103. Pentonville also agreed to be part of two research projects about substance misuse – one run by the NHS and another by a social enterprise, which they hope will give them some prisoner insights and help formulate their drug strategy.

## Security and intelligence reports

104. Staff submitted a number of intelligence reports suggesting that Mr Campbell was using drugs. Analysts often considered these to be 'building block' intelligence or, in other words, part of something that may or may not contribute to a bigger picture, but it was considered too early to tell.

105. The investigator spoke to Mr E, Pentonville's Head of Security. She reflected that it was good to see that staff submitted intelligence reports even when all they had were suspicions of drug use. What was not clear to her, however, was when a collection of reports should have triggered some action. Mr E said that he would have expected three reports, from different sources, and in a reasonably short time frame, to trigger a suspicion drug test and a cell search.

106. Staff submitted intelligence reports on 16, 17 and 19 May all relating to Mr Campbell's suspected PS use or his visiting a known user's cell. There is no evidence that Mr Campbell was asked to take a drugs test. On 22 May another intelligence report was submitted regarding Mr Campbell's involvement in weapons and phones. A prisoner had offered the information, referring to an incident he claimed to have witnessed approximately three weeks before. The same day that information was received, a suspected supplier's cell, who Mr Campbell had been seen visiting, was searched and nothing found. Mr Campbell's cell was also searched, and nothing was recovered from his either.

107. After this, staff submitted four intelligence reports relating to Mr Campbell's possible involvement in moving drugs around, fights and being under the influence of drugs. There is no evidence that apart from intelligence being shared with managers any other action was taken.

108. On 26 September, Mr Campbell was subject to a random (not suspicion-led) drug test. The results were positive.

109. While it is possible that some actions were taken and not recorded in the main record, or that actions were taken against other prisoners involved in some of these instances it seems that there was much information coming in about Mr Campbell that might have prompted security staff to act again when more instances occurred after his cell had been searched. However, we note the excellent and frequent support Mr Campbell was getting from his mental health in reach key worker and wonder what testing or cell searches might have achieved in terms of keeping Mr Campbell safe. We do not make a recommendation but the Governor and Head of Security might wish to consider the intelligence reports relating to Mr Campbell and analysts' subsequent decisions and consider any learning.

## Safeguarding Referrals

110. On 18 and 19 September, two separate members of staff made safeguarding referrals for Mr Campbell. Concerns had escalated about Mr Campbell over and above his drug use. His personal hygiene was poor, and staff thought he was possibly being bullied. The safeguarding referrals should have prompted a member of the safety team to interview Mr Campbell, discuss how he could be helped and potentially put in place support measures if they also thought he was a victim of bullying. However, neither referral was acted on because staff were either on leave or rest days.

111. The prison could not tell us why no minutes of the safeguarding meeting on 23 September were taken and we were not able to determine whether Mr Campbell was discussed at all, or any actions agreed. This was a missed opportunity to intervene at a point so close to Mr Campbell's death and the failure to respond to the referrals appears to have been the result of administrative failures. We make the following recommendation:

**The Head of Safety should ensure members of the team keep SIM meeting minutes and that, as far as is reasonably possible, there is adequate cover when staff are on leave to deal with safeguarding referrals.**

## Substance misuse care

112. Mr Campbell had an established history of substance misuse, and in the community his preferred drugs were cannabis and cocaine. However, in prison he tended to use PS (presumably because it was easy to obtain).

113. Mr Campbell was offered support from Phoenix Futures, the prison's psychosocial substance misuse service. He often did not want to engage or only did so for a short while.

114. The clinical reviewer found a lack of detail in the records regarding Mr Campbell's drug use and little evidence that staff discussed or considered his motivations for using substances or reasons why he may not wish or be able to stop. Although recognising that this may have been because he did not wish to engage, she found advice offered to him centred on harm minimisation and risk education. While she recognised the merit in this in helping to keep individuals who are going to use drugs safe, she did not feel it did much to address behaviour changes.

115. That being said, the clinical reviewer was pleased to see that after the incident which saw Mr Campbell admitted to hospital before his death, drug and alcohol services delivered widespread outreach and harm reduction advice to the prisoners.

116. Phoenix Futures were unable to see Mr Campbell every six weeks as expected because of capacity issues, but it seemed the healthcare and custodial management teams were unaware of this issue. Also, attempts where staff did try to see Mr Campbell but could not because he was under the influence of drugs were not always documented and there were periods where the Phoenix Futures task inbox was not monitored for a prolonged period. We bring these issues to the Phoenix Futures manager's attention.

## Mental Health care

117. The clinical reviewer concluded that the healthcare Mr Campbell received at Pentonville was equivalent to what he could have expected to receive in the community.

118. Nurse H's input was particularly impressive, and she paid attention to risk triggers and made efforts to communicate with Mr Campbell's community mental health team. However, there were other areas of Mr Campbell's mental health care which were not so good. Mr Campbell had a diagnosis of schizophrenia which manifested as voices and paranoid thoughts. Sometimes he believed the voices commanded him to eat his own waste or they would harm his children. Mr Campbell had also suffered from periods of depression in the past. He was receiving medication via an injection for his schizophrenia, but although he told the reception nurse he suffered from depression too there is no evidence that any action was taken to assess his mood.

119. A psychiatrist never formally reviewed Mr Campbell's medication while he was in prison even though he told staff he had sometimes took medication orally too which made him feel better. This was probably Haloperidol which, in the past, he had been prescribed in addition to his injection. While the clinical reviewer noted that it

is not best practice to top up injectable antipsychotic medication with oral, she felt there was scope to increase Mr Campbell's depot medication.

120. Mr Campbell had had a number of admissions to psychiatric hospitals in the past and his desire to return to one is evident in the clinical records. Staff told him he needed to be assessed, but this did not happen for five months, and a decision was made that he did not meet the criteria. The clinical reviewer considered that while this was the right decision because he was not acutely unwell, this was evident from the start. A consultant psychiatrist had assessed Mr Campbell at Wormwood Scrubs, five days before he transferred to Pentonville, and arrived at much the same conclusion. The clinical reviewer considered that the mental health team could have reassured Mr Campbell that they could cater for his needs, as had happened in the community, and not raised his hopes of a hospital transfer.

121. The clinical reviewer has made recommendations about Mr Cambell's substance misuse and mental health care, not directly related to his death, which the Head of Healthcare will wish to address.

## Good Practice

122. We are pleased to note that Mr Campbell's medical condition was fully considered and staff did not apply restraints when he was taken to hospital.

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