Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Petrou, a prisoner at HMP Pentonville, on 1 March 2021

A report by the Prisons and Probation Ombudsman

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

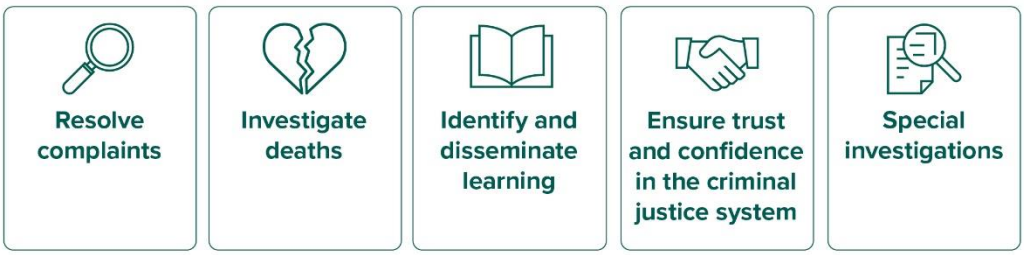
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 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

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.

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

Mr George Petrou was found hanged in his cell at HMP Pentonville on 1 March 2021. He was 56 years old. I offer my condolences to Mr Petrou's family and friends.

On 26 February 2021, Mr Petrou was sentenced to 22 years in prison, by video link. Despite Mr Petrou telling staff that he would rather die than spend a long time in prison, no one started suicide and self-harm prevention measures (known as ACCT). This was a missed opportunity to put support in place for Mr Petrou.

Although healthcare staff reviewed Mr Petrou after he was sentenced, our investigation found that Pentonville did not have a standard procedure for assessing whether there had been a change in risk for prisoners after attending video link court hearings.

My investigation also found that Mr Petrou did not have the support of a key worker as he should have done. I am also concerned that healthcare staff did not realise until 25 February 2021, that Mr Petrou had not been prescribed his antidepressant medication since mid-November 2020.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2021**

Contents

Summary

Events

1. On 21 March 2019, Mr George Petrou was remanded in custody, charged with rape and other sexual offences, and sent to HMP Pentonville.

2. Staff supported Mr Petrou using suicide and self-harm prevention measures (known as ACCT) on four occasions during his time at Pentonville. The last period of ACCT monitoring ended in August 2020.

3. Mr Petrou was under the care of the prison's mental health team throughout his time at Pentonville. They noted that he would need close monitoring around the time of his trial as he said that, if convicted, he would leave prison 'in a body bag'. During his trial, he said that he would rather die than spend a long time in prison.

4. On 26 February 2021, Mr Petrou was sentenced to 22 years in prison. He attended court by video link. Following sentencing, he was reviewed by healthcare staff, but they did not start ACCT procedures. Mr Petrou said that he did not want to be on an ACCT as the checks would interfere with his sleep, which would make him more anxious.

5. On 1 March, at around 8.55am, an officer arrived at Mr Petrou's cell to unlock him for medication. The officer found Mr Petrou hanging from the window in the toilet. The officer radioed a medical emergency code. Prison and healthcare staff quickly responded. They did not attempt resuscitation as it was clear Mr Petrou was dead. Paramedics attended and at 9.23am confirmed he had died.

Findings

6. We found that, overall, staff managed the ACCT procedures well. However, we are concerned that staff did not start ACCT monitoring after Mr Petrou was sentenced, given his clear risk factors for suicide.

7. We are concerned that there is no evidence prison staff had any meaningful interaction with Mr Petrou after he was sentenced by video link. There is nothing in his prison record about the hearing or sentence. Although healthcare staff met with Mr Petrou shortly after his sentencing and the next day, nobody met with him the day before he died, as they should have done.

8. The clinical reviewers concluded that the physical and mental health care Mr Petrou received was good and equivalent to that which he could have expected to receive in the community. However, they noted that staff did not realise until 25 February 2021, that he had not been prescribed his antidepressant medication since mid-November 2020.

9. We found that Mr Petrou did not have a key worker from January 2021 as he should have done. This was a missed opportunity to provide additional support to him, particularly around the time of his sentence.

10. An intelligence report, submitted in December 2020, that said Mr Petrou might be being bullied by another prisoner on the wing, was not actioned. Staff did not refer Mr Petrou to the Safety Intervention Meeting, and nobody considered violence reduction measures.

Recommendations

- The Governor and Head of Healthcare should ensure that staff assess prisoners' risk of suicide and self-harm based on their risk factors and not solely on their presentation and what the prisoner tells them.
- The Head of Healthcare should ensure that staff see prisoners at the agreed frequency, in line with their care or support plan.
- The Governor and Head of Healthcare should ensure that following a court appearance by video link:
    - the prisoner's NOMIS record is updated with details of the hearing and the outcome; and
    - staff should speak to the prisoner and consider whether their risk to themselves has changed.
- The Director General of HMPPS should review PSO 3050 and PSI 07/2015 to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person.
- The Head of Healthcare should review the systems for medicines management to identify systemic issues with prescribing.
- The Governor should ensure that during a restricted regime, key work is delivered in line with the Exceptional Delivery Model.
- The Governor should ensure that staff:
    - investigate suspected or alleged bullying in line with the prison's violence reduction policy;
    - support victims of bullying by making CSIP referrals; and
    - refer cases to the Safety Intervention Meeting where appropriate.

The Investigation Process

11. 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.

12. The investigator obtained copies of relevant extracts from Mr Petrou's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Petrou's clinical care at the prison.

14. On 8 April, the investigator interviewed six members of staff with the clinical reviewer. In addition, the investigator interviewed five members of staff and two prisoners. All interviews were conducted by video or telephone due to the COVID-19 restrictions.

15. We informed HM Coroner for London Inner North of the investigation. We have sent the Coroner a copy of this report.

16. We contacted Mr Petrou's brother and daughter to explain the investigation and ask if they had any issues they wanted the investigation to consider. Mr Petrou's family wanted to know:

    - Were Pentonville aware of Mr Petrou's mental health diagnosis when he arrived at Pentonville and how was this managed?
    - What medication was Mr Petrou prescribed and whether this was stopped before his court appearance?
    - Why Mr Petrou was not admitted to a mental health facility or located in the prison healthcare unit?
    - How frequently was Mr Petrou observed during his time in Pentonville and did this frequency increase after his court hearing, given his history of suicide attempts?
    - Was the prison aware Mr Petrou suffered from flashbacks due to his experience of childhood sexual abuse?
    - Why did staff not identify that Mr Petrou was not eating, losing weight and did not go out on exercise for fresh air?
    - Why was Mr Petrou not monitored after his sentence, despite a telephone call to the safer custody team expressing extreme concern for his safety?
    - Why did Mr Petrou live in a single cell with a toilet door?
    - Why did Pentonville not listen to Mr Petrou's telephone calls in the weeks before he died and identify that he was suicidal?

    We have answered their questions in this report and in the clinical review.

17. Mr Petrou's family received a copy of the initial report. Mr Petrou's daughter responded, via her legal representative, and said the detail of her contact with the prison raising concerns about her father's risk on 27 February was inaccurate, as she had also spoken to someone in the Control Room and was assured that the prison would do what they could to keep her father safe and check on him regularly. (The investigator found no evidence of this contact.)

18. The prison also received a copy of the report and did not identify any factual inaccuracies.

Background Information

HMP Pentonville

19. HMP Pentonville is a local prison in London that holds around 1,200 prisoners. The prison primarily serves the courts of north and east London. Practice Plus Group, in partnership with Enfield and Haringey Mental Health Trust, provides healthcare services.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Pentonville in April 2019. Inspectors said that ACCT support processes remained weak and were generally poorly managed. They reported that many ACCT caremaps were inadequate, that there was no continuity of case ownership and that there was limited multidisciplinary involvement in case reviews.

21. Inspectors reported that about a third of prisoners said they felt unsafe and that levels of violence were high. They said that investigations were currently not being completed and the Prison Service's new case management approach to managing perpetrators of violence and supporting victims (CSIP) had not yet been introduced.

22. Inspectors reported that there was sound governance of healthcare, that staffing levels and skills mix were sufficient, that there had been demonstrable learning from deaths in custody and regular sharing of health information between specialist teams at the health and wellbeing referral meetings.

23. Reporting on previous deaths at the prison, inspectors raised concerns that while PPO recommendations about healthcare had been met, most of the other PPO recommendations had not been achieved.

24. HMI Prisons Independent Reviews of Progress (IRPs) inspectors returned to Pentonville in January 2020. Inspectors reported that progress had been disappointingly slow and found that little had been done to respond to a very poor inspection report in 2019, until a few days before the IRP itself.

Independent Monitoring Board

25. 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 2020, the IMB reported that incidents of self-harm had risen over the reporting year. The Board noted the quality of the ACCT process had improved, but there was still a need to ensure all relevant participants were included in reviews.

26. The IMB noted that violence reduction measures (CSIP) could not be properly assessed as safer custody meetings had not been held and the information was not available.

27. The IMB found that some aspects of staff culture were obstructing positive engagement with and care for prisoners. However, the key worker scheme had had

a positive impact, including on the management of the ACCT process, but key worker provision had been severely impacted due to COVID-19.

28. The IMB reported that healthcare waiting times were equivalent to the community. The wellbeing centre received a national award for best team in clinical services .

Previous deaths at HMP Pentonville

29. Mr Petrou's death was the ninth at Pentonville since March 2019. Of the previous deaths, five were self-inflicted, one was drug related and two were from natural causes. We have previously made recommendations on assessment of risk of suicide and self-harm, the key worker scheme and investigating bullying allegations.

Assessment, Care in Custody and Teamwork (ACCT)

30. 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. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on Safer Custody.

Key worker scheme

31. HMPPS's policy document, Managing the Custodial Sentence Policy Framework, set out the minimum requirements needed to case manage those in custody from reception to the end of post-release supervision. This included the gradual introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:

- All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.

- All prison officers who work on a residential unit will be allocated a maximum of six prisoners. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

- Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance, so it is important that they are sufficient.

32. Key work was suspended on 24 March 2020 due to the COVID-19 pandemic. On 12 May, the Prison Service issued an Exceptional Delivery Model (EDM) for key work which was introduced nationally and provided a framework of principles within which establishments must operate but was for local determination on how to deliver this safely. The EDM set out the expectations of contact and that all contacts and concerns should be recorded on a prisoner's record. The EDM

identified priority prisoner groups for whom it was recommended that key work should continue, which included prisoners at risk of suicide or self-harm.

Key Events

33. On 21 March 2019, Mr George Petrou was remanded in prison custody, charged with rape and other sexual offences, and sent to HMP Pentonville. This was his first time in prison.

34. Mr Petrou had overdosed the day before he was remanded and had been on constant watch while at court. Prison staff started suicide and self-harm prevention measures (known as ACCT) when he arrived at Pentonville. They liaised with Mr Petrou's mental health team in the community who said that Mr Petrou had spent time in a psychiatric hospital and had a working diagnosis of psychotic depression, anxiety, adjustment disorder and traits of emotionally unstable personality disorder (EUPD).

35. On 28 May, during an ACCT review, Mr Petrou said, 'If I get convicted, I believe I have not done anything wrong, write this down, I will be taken out of prison in a body bag'. Mr Petrou spent time under constant supervision and was regularly reviewed by the prison's mental health team.

36. On 30 May, Mr Petrou was found guilty on some of the charges. The jury was unable to reach a decision on a number of other charges. He remained in custody awaiting sentence and a decision by the Crown Prosecution Service about whether to pursue a re-trial. Staff stopped ACCT monitoring on 31 July. Mr Petrou continued to be under the care of the prison's mental health team. They noted that an ACCT and increased observations would be needed around the time of Mr Petrou's trial.

37. Staff monitored Mr Petrou under ACCT from 4 to 17 September, after he scored highly on two questionnaires that assess the severity of depression and anxiety, and again from 8 October to 4 November, after his partner died.

2020

38. On 20 January 2020, Mr Petrou's re-trial started. However, on 19 March, his case was adjourned after he developed COVID-19 symptoms. Over the next few months, Mr Petrou slowly recovered. His mental health continued to be reviewed and monitored.

39. On 26 May, Mr Petrou said that he had been raped by a cellmate in October 2019 but did not wish to take the matter further. Staff gave him helpline numbers and told the prison safeguarding team. (Mr Petrou was later interviewed by the police, but there were no criminal charges). Mr Petrou also said he was being bullied by his current cellmate. Staff moved him to a single cell.

40. On 28 June, Mr Petrou was placed on the basic level of the incentives and earned privileges scheme (IEP) as he refused to have a cellmate, but the next day he agreed to have a cellmate and reverted to the standard regime. On 1 August, Mr Petrou was made enhanced on the IEP scheme.

41. On 14 August, staff started ACCT monitoring after Mr Petrou told a nurse that he was having flashbacks of the alleged sexual assault which meant he had trouble

sleeping. He was moved to a single cell. He said he felt safer and more settled but also lonely. Staff stopped ACCT monitoring on 20 August.

42. On 27 August, a supervising officer held a post-closure ACCT review with Mr Petrou. He noted that Mr Petrou said that staff had been 'fantastic' but that he wished he had been in a single cell much earlier. (Other than a couple of brief entries regarding Mr Petrou shielding from the COVID-19 virus in January 2021, this is the last meaningful entry on his prison record before he died.)

43. On 1 September, Mr Petrou's trial started. A consultant psychiatrist and a mental health nurse reviewed Mr Petrou. They noted that his trial was imminent and that he should remain on an ACCT (they were not aware that the ACCT had been closed as it was not recorded in Mr Petrou's medical record). They contacted the wing supervising officer to recommend that Mr Petrou should not be in a single cell.

44. On 29 September, a prison GP and the mental health nurse reviewed Mr Petrou. They noted the ACCT had been closed, despite the earlier note that ACCT measures should be in place during his trial, but that Mr Petrou had said he would prefer not to be on an ACCT as this would 'make him feel more suicidal'. The mental health team saw him regularly during his trial.

45. On 20 and 21 October, Mr Petrou was convicted of further offences. On 22 October, the mental health nurse saw Mr Petrou and noted that his mood was low, and that he was finding the court proceedings depressing. The next day Mr Petrou told the nurse that the trial had concluded, and he was awaiting the verdict. Mr Petrou said he did not want to be on an ACCT.

46. On 9 November, a psychiatrist met with Mr Petrou and discussed his court hearing. Mr Petrou said he was hoping to get a short sentence. The psychiatrist noted he thought monitoring would be needed at the point of sentence due to the potential increase in risk of self-harm.

47. On 17 November, a prison GP and the mental health nurse reviewed Mr Petrou. They did not record any concerns but noted that increased vigilance at the time of sentencing should be considered along with starting ACCT measures.

48. On 8 December, a prison officer on C Wing submitted an intelligence report which said that a prisoner on the wing may have been bullying prisoners, including Mr Petrou, for money and their canteen (purchases from the prison shop). There is no evidence that any action was taken.

2021

49. On 13 January 2021, a psychiatrist saw Mr Petrou. He recorded that Mr Petrou thought he would not be given a long custodial sentence. He noted his sentencing date of 25 February (though it was 26 February) and that the plan should be to closely monitor Mr Petrou around this time.

50. On 26 January, a forensic social worker with the mental health in-reach team took over Mr Petrou's care. He noted that Mr Petrou said he was anxious about sentencing but did not have any thoughts of suicide or self-harm. He set reviews for every two weeks, scheduled a psychiatric review for 17 February and recorded that Mr Petrou should be assessed again shortly after he was sentenced. On 28

January, he completed a review of Mr Petrou's CPA (Care Programme Approach – used to support those with complex mental health needs) and scheduled the next review in three months.

51. On 9 February, the forensic social worker met with Mr Petrou and noted in his medical record that he said, 'I'd rather die than spend a long time in prison'. He also noted that Mr Petrou said he had no current thoughts of suicide or self-harm.

52. On 16 February, Snaresbrook Crown Court contacted the Offender Management Unit (OMU) at Pentonville to tell them that Mr Petrou was to appear in court by video link at 2.00pm on 26 February.

53. The same day, a prison GP and the forensic social worker reviewed Mr Petrou's care. Two weekly reviews with the mental health in-reach team continued and they noted it was necessary for increased vigilance around the time of sentencing and that an ACCT would be opened if necessary.

54. On 17 February, a psychiatrist completed the scheduled psychiatric review. He recorded that there were no new concerns about Mr Petrou's physical or mental health. He noted that Mr Petrou was in a single cell, choosing to spend much of his time in there. They discussed Mr Petrou's impending court appearance on 26 February for sentencing. Mr Petrou told him that he was aware he could receive a long custodial sentence, but that his legal team had lodged an appeal, which he was pleased about. Mr Petrou said he had no thoughts of self-harm and when asked how he would manage if he was given a long sentence, he said he would not harm himself, and would tell staff of his thoughts.

55. The psychiatrist prescribed Mr Petrou with a five-day course of sleeping tablets (zopiclone). He also noted that the mental health in-reach team should review Mr Petrou before his sentence, discuss the management plan with prison staff and start ACCT measures if necessary.

56. On 24 February, the forensic social worker met with Mr Petrou, who told him that his sentencing date was in two days' time and would be by video link. He noted that Mr Petrou had some anxiety about being sentenced, but there were no concerns about his mental state, and he said he had no thoughts of suicide or self-harm. He told Mr Petrou that he had arranged for colleagues from the in-reach team to visit him following sentencing.

57. On 25 February, a healthcare assistant sent an email to the health and wellbeing team (HWB). She said that while having a thyroid blood test, Mr Petrou said that he had been feeling quite low and was having 'stupid thoughts' but did not intend to act on them. She gave him information on the HWB group and Mr Petrou said he was interested in engaging with the team and eager to speak to someone about his feelings. She noted that Mr Petrou was no longer receiving his antidepressant medication (citalopram) and sent a task for the GP to review his medication.

58. The same day, the forensic social worker spoke with a SO (Supervising Officer), one of the managers on C Wing. He told him that Mr Petrou was due to be sentenced, which could increase his risk of suicide and self-harm. He told the SO that the in-reach team would review Mr Petrou after sentencing and over the weekend. They agreed to share this information with the other wing manager, and

if there were any concerns then ACCT measures would start. While this discussion is recorded in Mr Petrou's medical record, there is nothing recorded on his prison record or the wing observation book.

59. Mr Petrou maintained contact with his family throughout his time at Pentonville. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to the calls made by Mr Petrou in the days before he died. At 9.59pm, he called his brother and they spoke for 87 minutes. There was nothing in the call to suggest Mr Petrou was in crisis.

26 to 28 February

60. On the morning of 26 February, Mr Petrou went to a health and wellbeing (HWB) meeting. A nurse noted that the GP would review Mr Petrou's medication, and he would be assessed by the in-reach team later that day.

61. The time of Mr Petrou's court appearance is not recorded, although earlier contact from Snaresbrook Crown Court to Pentonville indicated that the hearing would start at 2.00pm. Mr Petrou was sentenced to 22 years imprisonment, by video link. There is nothing about his court appearance or the outcome recorded on either Mr Petrou's prison record or the wing observation book. (In the Judge's summary he noted that Mr Petrou had declined to attend court the previous week and had left the hearing before sentence was passed.)

62. A SO said he was at his desk when an officer from C Wing told him that Mr Petrou had appeared in court, by video link, and that when he saw his family, he was upset and so left the room. (He could not remember the name of the officer, but we know who the officer was.) The officer had not been given any details about the court appearance or sentence, but had spoken to Mr Petrou, who assured her he was fine. We do not know when or who informed Mr Petrou of his sentence.

63. At 2.40pm, a prison GP met with Mr Petrou to review his medication and mood following sentence. Mr Petrou told the GP that he had been feeling low recently and had only just realised he had not been prescribed his antidepressant medication.

64. At 4.06pm, a nurse from the Inreach team went to see Mr Petrou in his cell. The nurse noted that Mr Petrou had panicked when he got to the video link room and did not wait to hear the sentence, so left. Mr Petrou told the nurse that he had not thoughts of suicide or self-harm and did not want an ACCT to be opened as he would not be able to sleep if checked regularly and this would increase his anxiety. Mr Petrou asked about his antidepressant medication. The nurse spoke to wing staff and asked them to check on Mr Petrou and provide support if his anxiety increased. The nurse told Mr Petrou he would visit him the next day.

65. At 4.38pm, Mr Petrou made his final telephone call, to his solicitor, which lasted 49 seconds (the call was not recorded because legal calls are confidential).

66. At 4.46pm, a prison GP spoke to a psychiatrist, who noted Mr Petrou's antidepressant medication had been stopped by accident and re-prescribed his citalopram.

67. Prisoner A on C Wing said he had known Mr Petrou for around 6-7 weeks. He said they met regularly, were both Greek Orthodox and used to pray and drink coffee together. He said when he served Mr Petrou's meal and asked how his sentencing had gone, Mr Petrou told him it had been delayed because of COVID-19. He said it was not a long conversation, but Mr Petrou seemed no different to his normal self.

68. On the morning of 27 February, a nurse from the mental health in-reach team met with Mr Petrou. Mr Petrou told her that he did not know the outcome of the sentencing hearing and would contact his solicitor. Mr Petrou told the nurse that his brother was providing support, that he was pleased his antidepressant medication had been prescribed and that he had no thoughts of suicide or self-harm. The nurse described Mr Petrou's mood as 'bright'.

69. There is no evidence that anyone from the mental health in-reach team met with Mr Petrou on 28 February.

70. A SO said that he spoke with Mr Petrou in the morning while unlocking prisoners for exercise, which Mr Petrou politely refused. The SO said Mr Petrou was sitting at his desk writing a letter and he had no concerns about him.

71. Prisoner A said he last saw Mr Petrou at around 4.00pm, when he took his meal to his cell. Mr Petrou was sitting at his desk writing a letter. There was nothing that caused concern. A SO said he spoke to Mr Petrou at around 4.50pm at the medication hatch. Mr Petrou told him to have a nice evening and that he would see him tomorrow. The SO had no concerns.

Monday 1 March

72. On 1 March at 5.40am, the night duty officer completed her early morning roll check (a count of all prisoners). She looked into Mr Petrou's cell through the observation panel and saw what she believed to be him lying in bed asleep and continued the rest of her count.

73. Two officers attended a morning briefing around 7.45am, before starting to unlock prisoners for their medication. They arrived at Mr Petrou's cell around 8.55am. Officer A unlocked the door, and he could see what he thought was Mr Petrou still in bed. Officer B entered and said there was a smell of body fluids. When he shook Mr Petrou to wake him up, he discovered a dummy (made up of filled plastic bags) had been left in the bed. The officers activated their body worn video cameras (BWVC). Officer B went to the toilet area, where he discovered Mr Petrou was suspended by a ligature attached to the window of the cell.

74. Officer A radioed a medical emergency code blue (used when a prisoner is not breathing which alerts healthcare staff and tells the control room to call an ambulance immediately) and shouted for staff to lock prisoners back into their cells. A SO responded and assisted both officers in cutting the ligature and moving Mr Petrou to the floor. They did not begin cardiopulmonary resuscitation as it was evident Mr Petrou was already dead. A nurse responded to the code blue and said that Mr Petrou was stiff, his blood had pooled, and his pupils were fixed and dilated, all signs Mr Petrou had been dead for some time.

75. The London Ambulance Service confirmed they received a request for an emergency ambulance at 9.00am and arrived at Mr Petrou's cell at 9.06am. Paramedics completed their assessments and at 9.23am recorded that Mr Petrou had died.

Information after Mr Petrou's death

76. Officers found a suicide note in Mr Petrou's cell dated Sunday 28 February which said, 'My minds exhausted. Gone to find my mum. *9.30pm* Goodbye world. DNR – Do Not Resuscitate'. Mr Petrou had also left some belongings in a bag and a note which read; 'Kev you helped me loads. Thank you xx'.

77. Prisoner B who lived on C Wing said Mr Petrou told him that he had walked out of his video link court appearance and he could tell he was upset. He said he told an officer (name not known) that he was concerned about Mr Petrou and a female officer to 'keep an eye' on him.

78. On 1 March, Safer Custody staff discovered that Mr Petrou's daughter had left a voicemail message on Saturday 27 February at around 1.30pm, which said she was concerned for her father's welfare, that he had mental health issues and had previously felt suicidal.

Contact with Mr Petrou's family

79. On 1 March, the prison appointed a family liaison officer (FLO). While under normal circumstances next of kin should, wherever possible, be informed of a death in person by a FLO, Government advice at the time prohibited all but essential travel and required social distancing to prevent the spread of the COVID-19 virus. At around 11.00am, the FLO informed Mr Petrou's brother of his death by telephone and later spoke to Mr Petrou's daughter. The prison provided ongoing support and contributed towards the costs of Mr Petrou's funeral, which was held on 26 April, in line with national policy.

Support for prisoners and staff

80. After Mr Petrou's death, a senior prison manager debriefed all 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.

81. The prison posted notices informing other prisoners of Mr Petrou'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 the death. Prisoner A said he felt very well supported.

Post-mortem report

82. We have not yet received the post-mortem or toxicology reports from the Coroner.

Findings

Assessment and management of Mr Petrou's risk of suicide and self-harm

83. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures, known as ACCT, that staff must follow when they identify prisoners at risk of suicide and self-harm.

84. Mr Petrou was supported under ACCT on four occasions at Pentonville. We found that he received a good level of support from both healthcare and prison staff during those periods.

85. We are concerned, however, that Mr Petrou was not being monitored under ACCT when he died. In November 2020, healthcare staff noted that increased vigilance would be needed around the time Mr Petrou was sentenced and an ACCT would need to be considered. Once staff were aware of the scheduled sentencing date, 26 February 2021, there were further notes that Mr Petrou would need to be closely monitored around that time. On 9 February, Mr Petrou told staff he would rather die than spend a long time in prison. On 25 February, Mr Petrou told a healthcare assistant that he had been feeling quite low and was having 'stupid thoughts', though he said he did not intend to act on them.

86. We are very surprised that after Mr Petrou was sentenced to 22 years in prison, healthcare staff did not open an ACCT. Mr Petrou told them that he did not want an ACCT to be opened as the checks would interrupt his sleep, which would increase his anxiety. We do not consider this was a valid reason not to open an ACCT. All the indications were that Mr Petrou was at a very high risk of suicide if he was sentenced to a long time in prison. Staff missed an opportunity to put support measures in place. We recommend:

    The Governor and Head of Healthcare should ensure that staff assess prisoners' risk of suicide and self-harm based on their risk factors and not solely on their presentation and what the prisoner tells them.

87. We note that healthcare staff saw Mr Petrou after he was sentenced on 26 February, and on 27 February, but they did not see him on 28 February. This was despite a record that someone should see him every day. We recommend:

    The Head of Healthcare should ensure that staff see prisoners at the agreed frequency, in line with their care or support plan.

Court appearance

88. PSI 07/2015, Early days in custody, says that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video link. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, says that prisons must have procedures in place so that prisoners who have attended court by video link who request help, or who are

identified as needing help, from healthcare staff, are told how to access it and are able to receive it in an appropriate timeframe.

89. While we accept that Mr Petrou was assessed by healthcare staff following his video link appearance on 26 February (as this had been pre-arranged when healthcare staff found out when he was due to be sentenced), there appeared to be no standard procedure for prison staff to assess whether a prisoner's status or demeanour had changed or whether they might need to see healthcare staff after a video link court appearance. There was nothing noted in Mr Petrou's prison record about the hearing on 26 February or the outcome.

90. After Mr Petrou's death, Pentonville introduced a proforma for video link staff to record information after a hearing. The proforma prompts staff to contact the duty nurse if there has been a change in the prisoner's status, or if they are sentenced, and to make an entry on the prisoner's record and inform the Offender Management Unit (OMU). While this is an improvement, it still relies too heavily on the prisoner providing accurate information.

91. The OMU manager told us that she has not been able to establish what time the OMU received details of Mr Petrou's sentence but was told by the video link clerk that the warrant from Snaresbrook Crown Court had been received around 4.00pm on 26 February. She said that since Mr Petrou's death, she has met with senior managers who are working on improving the process of sharing information and recognising when risk to a prisoner may increase.

92. We recommend:

The Governor and Head of Healthcare should ensure that following a court appearance by video link:

- **the prisoner's NOMIS record is updated with details of the hearing and the outcome; and**

- **staff should speak to the prisoner and consider whether their risk to themselves has changed.**

93. An increasing number of prisoners are being sentenced by video link, especially during the COVID-19 pandemic. As they do not leave the prison, they are not subject to the standard screening procedures that they would have when returning to the prison and passing through reception. Prisoners passing through reception would not only be assessed for risk of suicide and self-harm but also those with a change in status, including those who have been sentenced, would be referred to healthcare staff. This does not happen for video link hearings. We therefore consider that national guidance should be reviewed to ensure that processes are in place for assessing prisoners at risk of suicide and self-harm after a court appearance by video link. We make the following recommendation:

The Director General of HMPPS should review PSO 3050 and PSI 07/2015 to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person.

Clinical care

94. The clinical reviewer concluded that, overall, Mr Petrou's clinical care was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that Mr Petrou's mental health care was well managed and that he received appropriate care when he had COVID-19 symptoms.

Antidepressant medication

95. On two occasions, Mr Petrou's antidepressant medication (citalopram) was not prescribed. On 25 June 2019, it was discovered that Mr Petrou had not been prescribed citalopram for around two months. On 25 February 2021, it was discovered that the medication had not been prescribed since mid-November 2020.

96. The clinical reviewer found these were oversights and not a clinical decision to stop antidepressant medication. Mr Petrou was regularly reviewed by the mental health team during both periods and while there was no significant change, Mr Petrou did speak of increased anxiety which could possibly be attributed to not receiving his medication. We recommend:

The Head of Healthcare should review the systems for medicines management to identify systemic issues with prescribing.

Key work scheme

97. Key work was formally suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. On 12 May, the Prison Service issued an Exceptional Delivery Model (EDM) for key work which set out the priority prisoner groups for whom it was recommended that key work should continue. The priority groups included prisoners at risk of suicide or self-harm and prisoners who had been advised to shield because they had been assessed as clinically extremely vulnerable to COVID-19.

98. Mr Petrou had a key worker session on 19 August 2020, while he was on an ACCT, but he had no further key work sessions after that. In January 2021, Mr Petrou was assessed as clinically extremely vulnerable to COVID-19 and he started shielding. In line with the EDM, he should have been allocated a key worker.

99. We acknowledge the significant pressures faced at Pentonville around the time of Mr Petrou's death because of reduced staff numbers and the impact of the COVID-19 restrictions. However, we consider that Mr Petrou should have had a key worker from January 2021, while he was shielding. We recommend:

The Governor should ensure that during a restricted regime, key work is delivered in line with the Exceptional Delivery Model.

Violence reduction

100. A Prisons and Probation Ombudsman (PPO) publication in October 2011, Violence reduction, bullying and safety, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-

inflicted deaths in 2013-2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly.

101. Pentonville has a violence reduction policy dated 20 February 2020, which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation, or violence. An intelligence report was submitted on 8 December 2020, which said that Mr Petrou (and other prisoners) were possibly being bullied by a prisoner on C Wing for money and their canteen. There is no record of this information on Mr Petrou's prison record and no evidence this information was shared with Safer Custody or if any follow up action was taken to investigate. There is no evidence that Mr Petrou raised any concerns about being bullied with staff.

102. We are concerned that more was not done in response to the information submitted to security. Violence reduction measures (Challenge, Support and Intervention Plan (CSIP)) should have been considered in response to this intelligence report.

103. Staff at Pentonville hold a weekly Safety Intervention Meeting (SIM) to discuss managing the risks to prisoners and the prison. It is attended by heads of function, including security, safer custody and healthcare managers. There is no evidence that Mr Petrou, despite his vulnerabilities and assessed high risk of suicide and self-harm around the time of sentencing, was referred or considered by the SIM. This was a missed opportunity to provide him with additional support.

104. We recommend:

The Governor should ensure that staff:

- **investigate suspected or alleged bullying in line with the prison's violence reduction policy;**
- **support victims of bullying by making CSIP referrals; and**
- **refer cases to the Safety Intervention Meeting where appropriate.**

Safer Custody helpline

105. On Saturday 27 February, Mr Petrou's daughter left a voicemail message on the Safer Custody hotline saying she was concerned for her father's safety, but staff did not listen to this message until after Mr Petrou had died.

106. A senior manager told the investigator that the recorded message on the Safer Custody hotline advises callers that the line is monitored Monday to Friday 9.00am to 5.00pm and that if the caller requires an urgent response, or the call is an emergency, they should call the prison's Control Room number which is always staffed. The Control Room did not receive a call.

107. Following Mr Petrou's death, Pentonville reviewed how it monitors voicemail messages. The senior manager told the investigator that every Friday, the Safer Custody Team email the weekend duty managers and operational managers to

remind them to periodically check the Safer Custody voicemail. Managers are asked to respond to any immediate risks or send an email to the Safer Custody Team mailbox to alert them to any non-urgent matters.

108. As Pentonville has already reviewed and changed the process for monitoring Safer Custody voicemail messages at weekends, we make no recommendations.

Inquest

109. The inquest into Mr Petrou's death concluded in October 2024 and recorded Mr Petrou's death was suicide due to partial suspension.

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 l 020 7633 4100