Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Benjamin Onyeabo, a prisoner at HMP Pentonville, on 5 January 2025

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 Benjamin Onyeabo died on 5 January 2025, after he was found hanging in his cell at HMP Pentonville. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 55 years old. I offer my condolences to Mr Onyeabo's family and friends.

Mr Onyeabo had been at Pentonville for only four days. I am satisfied that there was no indication that he was at imminent risk of suicide during that time and that staff could not have foreseen his actions.

I make no recommendations.

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 **September 2025**

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Summary

Events

1. On 1 January 2025, Mr Benjamin Onyeabo was sentenced to 58 weeks in prison for criminal damage to property and threatening a person with a blade. He was sent to HMP Pentonville. He had spent time at Pentonville many times before. He had never self-harmed or been assessed as at risk of suicide or self-harm during his previous periods in custody.

2. During his reception screening, Mr Onyeabo said that he had no thoughts of suicide or self-harm and had no previous record of self-harm.

3. Two members of chaplaincy staff, who knew Mr Onyeabo well from previous sentences, visited him separately on 2 and 3 January. Although Mr Onyeabo expressed regret to them about his alleged offences, neither member of staff had any concerns about his risk of suicide or self-harm.

4. On 5 January, an officer unlocking cells saw Mr Onyeabo in what he described as an awkward position. He entered the cell and saw a ligature around Mr Onyeabo's neck, tied to the top bunk. He radioed a medical emergency code. Officers and healthcare staff responded and began CPR.

5. Paramedics arrived and continued with the resuscitation attempts. However, these were unsuccessful and paramedics pronounced life extinct at 10.27am.

6. After Mr Onyeabo's death, his journal was found in his cell which indicated that he had lost hope and did not want to face another period in prison.

Findings

7. Mr Onyeabo gave no indication that he was at risk of suicide or self-harm when he arrived at Pentonville or during his next few days there. We are satisfied that staff could not have foreseen his actions.

8. The clinical reviewer identified no concerns with the healthcare provided to Mr Onyeabo at Pentonville and concluded that it was equivalent to that which he could have expected to receive in the community.

9. We make no recommendations.

The Investigation Process

10. HMPPS notified us of Mr Onyeabo's death on 6 January 2025.

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 visited Pentonville on 15 January. She obtained copies of relevant extracts from Mr Onyeabo's prison and medical records.

13. The investigator interviewed seven members of staff by video call and at Pentonville between January and April.

14. NHS England commissioned an independent clinical reviewer to review Mr Onyeabo's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews in January, March and April.

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

16. The Ombudsman's office contacted Mr Onyeabo's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Her solicitor asked for the details of the circumstances of Mr Onyeabo's death. We have addressed this in the report.

17. We shared our initial report with HMPPS. They found no factual inaccuracies.

18. We sent a copy of our initial report to the solicitors representing Mr Onyeabo's sister. They did not notify us of any factual inaccuracies.

Background Information

HMP Pentonville

19. 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

20. 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.

21. 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 extremely 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

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 March 2024, the IMB reported that many prisoners spent approximately 22 hours a day locked in their cells, only leaving to collect their food, shower, exercise, attend wing recreation and complete admin tasks. The Board considered the amount of time out of cell was unacceptable, reduced opportunities for rehabilitation, was inhumane and amounted to “warehousing” a significant proportion of the population. The Board reported that staffing levels and competing regime priorities limited resources for prisoners. The Board noted that incidents of self-harm had increased by 13% compared to the previous year, but there were no identifiable themes behind this.

Previous deaths at HMP Pentonville

23. There were five deaths at Pentonville in the three years before Mr Onyeabo’s death. Two of these were self-inflicted and three were due to natural causes. Up to the end of June 2025, there have been three further deaths at the prison, two self-inflicted and one from natural causes.

Key Events

24. On 1 January 2025, Mr Benjamin Onyeabo was convicted of criminal damage to property and threatening a person with a blade, and sentenced to 58 weeks in prison. He was sent to HMP Pentonville. He had previously spent time in Pentonville on 21 occasions and had a history of mental health issues, alcohol and cannabis misuse.

25. The reception officer noted that Mr Onyeabo told her that he had no intentions of suicide or self-harm and had no previous record of self-harm. For his cell sharing risk assessment staff noted that historically, as Mr Onyeabo suffered from mental health issues and had found it difficult to share, he was assessed as at high risk of harming a cellmate. He was allocated a single cell on A Wing, the first night centre.

26. At his healthcare screen, Mr Onyeabo told the reception nurse that he had a personality disorder and had no thoughts of suicide or self-harm. From the history in his medical records, it was noted he had a history of cannabis and alcohol problems. The nurse referred him for a psychosocial substance misuse assessment.

27. A healthcare assistant completed a Wellman assessment as a form of secondary screening on 2 January. Mr Onyeabo told her he had high blood pressure and suffered from post-traumatic stress disorder (PTSD). Later that day, staff discussed Mr Onyeabo at an Early Days in Custody (EDIC) meeting and made a plan for the psychosocial support team to complete an assessment and for him to rejoin the waiting list for referral to groups (as he had been on a waiting list during his previous time at Pentonville in November 2024). On 2 January, a member of the psychosocial support team completed the assessment and noted that Mr Onyeabo told her that he had alcohol issues with which he would like help.

28. The same day, a Catholic chaplain at the prison visited Mr Onyeabo. She said she had known him for over ten years when he had been in and out of prison. She said Mr Onyeabo was remorseful and said he was evil because he had committed offences after drinking and had no recollection. He asked her to enrol him for a meditation group which he had previously attended. She said he did not discuss any thoughts of suicide or self-harm.

29. On 3 January, a Quaker chaplain at the prison spoke to Mr Onyeabo by his cell door. He said during their 20-minute conversation, Mr Onyeabo expressed feeling inadequate at the circumstances of his latest arrest. However, the chaplain noted that having known Mr Onyeabo for over nine years, he displayed his typical demeanour which he described as reading, journalling and grumbling. He said he did not discuss any thoughts of self-harm.

30. On 3 January, Mr Onyeabo was allocated a cell on G Wing, of which he was the sole occupant.

Events of 5 January 2025

31. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 5 January. She also obtained information from London Ambulance Service.

32. That morning, Officer A was completing a routine roll and welfare check of all cells (officers check every cell to ensure prisoners are accounted for and responsive). (Officer A subsequently resigned from the prison service and Pentonville could not provide any contact details for him. We were not able to interview him as part of this investigation.) CCTV shows that he arrived at Mr Onyeabo's cell at 7.39am. In his police statement, Officer A said that he looked through the observation panel. The light was on and he saw Mr Onyeabo sitting on the floor, at the corner of the bed, away from the cell door with his legs outstretched. Officer A knocked on the cell door. There was no response so he said that he kicked against the cell door and Mr Onyeabo raised his arm. Officer A said he was not entirely happy with the response so he called for a colleague, Officer B.

33. CCTV shows that Officer B arrived at 7.42am. In his police statement, he said he saw Mr Onyeabo sitting on the floor by the corner of his bed, facing the toilet. He thought this was unusual so he opened the cell door and both officers entered the cell. CCTV shows Officer B speaking. In his statement, he said he asked Mr Onyeabo if he was okay and Mr Onyeabo responded by waving his arm. He asked him again if he was okay and he said he made a verbal response. The officers left the cell and Officer B went to report this to the senior officer in charge, a Custodial Manager (CM). He said he told the CM that Mr Onyeabo was sitting on the floor and they had seen physical movement and obtained a verbal response from him. The CM told him that they could continue with their checks.

34. CCTV shows Officer A looking through Mr Onyeabo's cell observation panel at 8.38am, 8.44am and 9.09am as he was walking along the landing.

35. At 9.30am, Officer C was unlocking the cell doors so that prisoners could leave their cells to either go to the exercise yard, shower, socialise or do their laundry. He arrived at Mr Onyeabo's cell, called out to Mr Onyeabo and then moved onto the next door. However, he noticed Mr Onyeabo's legs were not in a natural position so he returned to the cell and entered, calling out to him. There was no response, so he walked towards him and saw that he had tied a ligature around his neck and he was suspended from the top bar of the bunk bed. He stepped out of the cell to check the cell number, radioed a medical emergency code, and then went back in and held Mr Onyeabo to take his weight. He used his anti-ligature knife to cut the ligature and he placed Mr Onyeabo on the floor. He checked for a pulse but there was none and Mr Onyeabo's eyes were open.

36. A Supervising Officer (SO) was the first to arrive at the cell and he started CPR. Another SO assisted. A prison paramedic arrived at the cell with an emergency bag and defibrillator. He said that he saw officers performing chest compressions. He placed the defibrillator pads on Mr Onyeabo's chest and the machine advised no shock. Prison officers continued with the chest compressions. The prison paramedic inserted an Igel (airway) and staff continued with the compressions as prompted by the defibrillator. Two nurses also assisted.

37. The ambulance log notes the emergency telephone call was received at 9.34am. Ambulance crews were with Mr Onyeabo at 9.46am and continued with the resuscitation attempts. The advanced paramedic pronounced life extinct at 10.27am.

Notes recovered from Mr Onyeabo's cell

38. After Mr Onyeabo's death, journalling notes were found in his cell. Some were extracts of Bible chapters. In a note dated 1 and 2 January, Mr Onyeabo said that his name had been ruined by his own actions, he was facing six months in prison and that he no longer had any energy or hope. He signed off as "completely lost" at 9.40am. In another note dated Saturday 4 January at 12.20pm, Mr Onyeabo said he was upset at being back on G Wing. He outlined his thoughts and said that "suicide requires more effort than just 'being'" and he felt that he would "be denied any eternal rest". He signed off and noted the time as 1.08pm.

Contact with Mr Onyeabo's family

39. On 5 January, the prison appointed a family liaison officer (FLO). The FLO and an officer visited Mr Onyeabo's sister that day to tell her that Mr Onyeabo had died and offer support.

40. The prison contributed to the cost of Mr Onyeabo's funeral, in line with national guidelines.

Support for prisoners and staff

41. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner 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) to identify prisoners most affected by the death.

42. After Mr Onyeabo's death, the CM 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.

43. The prison posted notices informing other prisoners of Mr Onyeabo'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 Onyeabo's death. They also deployed Listeners to the wing to offer support to prisoners when Mr Onyeabo died.

Cause of death

44. The Coroner notified us that Mr Onyeabo's provisional cause of death was ligature compression. The post-mortem report is still awaited.

Findings

Assessment of risk

45. The Prison Safety Policy Framework sets out the procedures (known as ACCT) that staff must follow if they identify that a prisoner is at risk of suicide or self-harm. It lists the risks and triggers that can indicate increased risk of self-harm.

46. Mr Onyeabo had spent several periods of imprisonment at Pentonville. He had never been assessed as needing support using ACCT procedures. He had never had any self-harm incidents at Pentonville.

47. When Mr Onyeabo arrived at Pentonville on 1 January 2025, and during the next three days, he did not give any indication that he was at risk of suicide or self-harm. He engaged with two members of the prison chaplaincy team who he had known for several years. When asked by staff at various different times, he always said he had no thoughts of suicide or self-harm. He did not display any behaviour or present with any new risk factors to indicate to prison or healthcare staff that he was at an increased risk of suicide or self-harm.

48. We are satisfied that staff could not have foreseen Mr Onyeabo's actions.

Clinical care

49. The clinical reviewer concluded that the healthcare Mr Onyeabo received at Pentonville was equivalent to that which he could have expected to receive in the community.

50. The clinical reviewer noted that Mr Onyeabo was seen and assessed on his arrival at the prison and staff made arrangements to manage his physical health and to support him with his substance misuse problems.

51. The clinical reviewer made two recommendations, not directly related to Mr Onyeabo's death, which the Head of Healthcare will wish to address.

52. We make no recommendations.

Inquest

53. At the inquest, held from 11 to 22 May 2026, the jury reached a narrative conclusion:

> "Mr Onyeabo deliberately chose to suspend himself by a ligature but the evidence does not fully explain whether or not he intended the outcome to be fatal. There are references to suicide in Mr Onyeabo's writings however these do not demonstrate he intended to end his life while suspended by ligature."

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