Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gareth Chumber-Kelly, a prisoner at HMP Pentonville, on 17 July 2023

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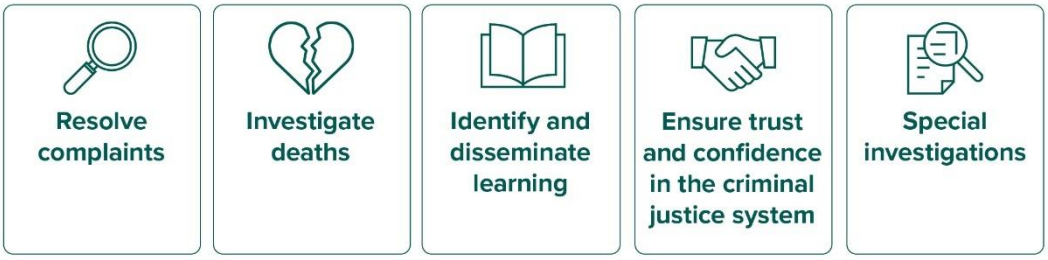
OUR VISION

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 HM Prison and Probation Service 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 Gareth Chumber-Kelly was found hanged in his cell at HMP Pentonville on 17 July 2023. He was 33 years old. I offer my condolences to his family and friends.

Mr Chumber-Kelly died five days after he arrived at Pentonville. He had several significant risk factors for suicide and self-harm and had been assessed at court as presenting a risk of suicide. Although prison and healthcare staff received information about his risk, they did not review it. This delayed the implementation and quality of suicide and self-harm prevention procedures (known as ACCT).

The management of ACCT procedures, once opened, was poor. Mr Chumber-Kelly's ACCT documentation lacked detail and was incomplete. Healthcare staff did not contribute to his first case review, and staff misjudged his risk of suicide and self-harm.

Mr Chumber-Kelly was not given access to a phone the weekend he arrived at Pentonville and he had not been given a prison phone account before his death. I am increasingly concerned about the operation of prison phone accounts – both the lack of parity with contracts for those in the community and that too little priority is given to promptly ensuring prisoners have the ability to phone family and friends, particularly at times of crisis.

The emergency response when Mr Chumber-Kelly was found was delayed, chaotic and lacked leadership.

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 **July 2025**

Contents

Summary

Events

1. On 13 July 2023, Mr Gareth Chumber-Kelly was remanded to HMP Pentonville, charged with attempted robbery and possession of an imitation firearm.

2. While Mr Chumber-Kelly was at court, a healthcare support worker from the Police and Court Liaison and Diversion Service (PCLDS) reviewed him and noted in his person escort record (PER) that he said he would kill himself if he went to prison. She completed a suicide and self-harm warning form and emailed the prison's mental health team.

3. However, when Mr Chumber-Kelly arrived at Pentonville, a reception supervising officer (SO) signed to say he had reviewed the PER and that there was nothing to indicate a risk of suicide or self-harm. A nurse screened him but did not have access to the email, PER or the suicide and self-harm warning form.

4. An officer conducted Mr Chumber-Kelly's first night interview but Mr Chumber-Kelly was not given a prison phone account so he could not call his family.

5. On 14 July, healthcare staff discussed Mr Chumber-Kelly at a referrals meeting. No one from the mental health team attended.

6. Later that day, Mr Chumber-Kelly made a cut to his arm as he felt frustrated about not being able to tell his family he was in prison. Prison staff started suicide and self-harm monitoring, known as ACCT, and an officer arranged for Mr Chumber-Kelly to phone his father.

7. On 15 July, an SO conducted a first ACCT case review. The SO recorded that Mr Chumber-Kelly said he felt better having had contact with his family.

8. At around 12.30pm on 17 July, Mr Chumber-Kelly's cellmate found him hanging from a ligature and pressed the emergency cell bell. An officer attended and radioed a medical emergency code blue at 12.34pm before going into the cell and cutting the ligature. Additional prison staff arrived but did not start cardiopulmonary resuscitation (CPR).

9. An emergency response nurse initially went to the wrong cell having been given incorrect information. While on her way to the correct cell, she saw an officer escorting a prisoner away from the cell and cancelled the code blue as she thought the incident had been addressed. After noticing that officers continued to gather outside that cell, she went to the cell and saw Mr Chumber-Kelly lying on the floor. She reinstated the code blue and started CPR at 12.42pm.

10. At 1.31pm, paramedics took Mr Chumber-Kelly to University College Hospital, London, where staff pronounced life extinct.

Findings

Identifying and managing the risk of suicide and self-harm

11. Staff did not identify the information about Mr Chumber-Kelly's heightened risk of suicide as set out in his PER, suicide and self-harm warning form and the email from the liaison and diversion team and therefore missed an opportunity to start suicide and self-harm procedures earlier.

12. Aspects of Mr Chumber-Kelly's ACCT document were incomplete and aspects of the process were not managed well or in line with national policy. Staff failed to assess Mr Chumber-Kelly's risk to himself accurately at the first case review. Had they considered all the risk information available, they might have assessed him as at higher risk of suicide and self-harm and increased the protective measures.

PIN phone access

1. Mr Chumber-Kelly had not been set up with a prison phone account by the time he died, which meant he could not freely contact his family for support at a time of heightened vulnerability. While Mr Chumber-Kelly was allowed to briefly phone his father, we are concerned that procedures at Pentonville, and across the prison estate, do not allow for prisoners to be allocated a prison phone account at weekends, or with sufficient priority on their arrival.

Emergency response

13. The emergency response was chaotic and the clinical reviewer noted the lack of leadership. The sequence of events led to a delay of around seven minutes before control room staff called for an ambulance.

14. While we recognise the distress and shock at finding Mr Chumber-Kelly hanging, prison staff should have started CPR immediately but instead waited for healthcare staff.

Clinical care

15. The clinical reviewer found that the care Mr Chumber-Kelly received at Pentonville was not equivalent to that which he could have expected in the community.

16. The clinical reviewer considered that the prison's mental health team should have seen and actioned PCLDS' email on 13 July and PCLDS should have told the mental health team by phone. She also considered that healthcare staff failed to take into account all Mr Chumber-Kelly's risk factors and a member of the mental health team should have attended the referrals meeting on 14 July.

Recommendations

- The Governor and Head of Healthcare should review the training for reception and induction staff to ensure they understand how to identify prisoners at risk of suicide and self-harm, including that all relevant risk information, including the PER, is properly shared and examined as part of the reception/first night process.

- The Director General of HMPPS should review the current process for and priority given to setting up prison phone accounts for newly arrived prisoners (both from court and on transfer) to ensure that they can call family and friends without delay.

- The Head of Healthcare should ensure that healthcare staff are fully prepared to effectively manage emergency response situations.

The Investigation Process

2. HMPPS notified us of Mr Chumber-Kelly's death on 17 July 2023.

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

4. The investigator obtained copies of relevant extracts from Mr Chumber-Kelly's prison and medical records.

5. The investigator interviewed five members of staff at Pentonville between 21 September and 9 October 2023. He also interviewed three members of staff by video conference and one by telephone between 2 and 3 October.

6. NHS England (NHSE) commissioned a clinical reviewer to review Mr Chumber-Kelly's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

7. We informed HM Coroner for Inner North London of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

8. Our investigation was suspended between December 2023 and 10 January 2025, while waited for the post-mortem report.

9. The Ombudsman's office contacted Mr Chumber-Kelly's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Chumber-Kelly's mother asked:

    - why staff failed to identify his risks of suicide and self-harm;
    - what safeguarding procedures were in place; and
    - if he should have been under constant supervision.

    We have addressed these concerns in this report.

10. The solicitor representing Mr Chumber-Kelly's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Pentonville

12. HMP Pentonville is a local prison in London. 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 Prison

13. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Pentonville in July 2022. Inspectors found that support for prisoners in crisis and those subject to ACCT monitoring was not good enough. Few prisoners who were monitored under ACCT procedures reported that they had felt cared for. Inspectors noted that while ACCT case reviews were detailed, associated caremaps were often incomplete or not used effectively. They also found that there was insufficient leadership and oversight of suicide and self-harm prevention work. Inspectors also noted that the Pentonville's reception area was bleak and needed refurbishment. They found that prisoners could spend hours waiting in reception and observed instances of officers being impatient and unwelcoming.

14. In April 2023, inspectors returned to Pentonville to conduct an independent review of progress. They found that governance of work to prevent suicide and self-harm had improved. Leaders had implemented a single case manager model to improve the quality and consistency of the ACCT process but the quality of documentation was still not good enough. Inspectors also noted that although the reception area and first night centre had been improved, the approach staff took to provide basic items for daily living was inconsistent.

Independent Monitoring Board

15. 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 there had been positive improvements to reception and early days processes. However, they also noted that the quality of ACCT documents remained inadequate and that the safer custody department struggled to fulfil its remit due to staffing shortages and changes to management.

Previous deaths at HMP Pentonville

16. Mr Chumber-Kelly was the ninth prisoner to die at Pentonville since July 2020. Of the previous deaths, four were from natural causes, three were self-inflicted and one was drug related. To the end of February 2025, there have been four deaths since, two self-inflicted, one drug related and one from natural causes.

17. In our previous investigations into self-inflicted deaths at Pentonville we identified concerns with the ACCT process. It is disappointing that we have found similar issues in this investigation.

Assessment, Care in Custody and Teamwork

21. 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. 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.

22. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. 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 was set out in Prison Service Instruction (PSI) 64/2011 at the time of Mr Chumber-Kelly's death. It has since been replaced by the Prison Safety Policy Framework.

Prison phone accounts

23. In public sector prisons in England and Wales, prisoners are given an eight-digit personal identification number that enables them to make calls to certain agreed numbers, and this account remains with them for the duration of their time in prison. The prison phone system does not accept incoming calls.

24. On reception into prison, PSI 49/2011 on prisoner communication services states that governors must have local arrangements in place to allow a call to be made in the first 24 hours. For a prisoner to make a call, their personal phone account must have been set up and credited with funds. A call made in reception or in the first night accommodation can be funded in two ways:

    - using a generic account, pre-funded with credits which are paid for from public funds to enable prisoners to make a short call;

    - after the prisoner has signed a form agreeing to the terms and conditions of the use of the prison phone system and having funds credited to the account.

25. Prison administrators are generally responsible setting up a prisoner's phone account after he has signed the relevant form. They do not tend to work at weekends so if a prisoner arrives on a Friday, there is often a delay.

Key Events

13 July 2023

23. On 13 July 2023, Mr Gareth Chumber-Kelly was remanded to prison, charged with attempted robbery and possession of an imitation firearm. He had a history of depression and was prescribed methadone to treat opiate withdrawal.

24. At 11.28am, while Mr Chumber-Kelly was at court, a healthcare support worker from the Police and Court Liaison and Diversion Service (PCLDS), reviewed him. She noted that Mr Chumber-Kelly had attempted suicide in the past and said he would kill himself if he went to prison. She completed a suicide and self-harm warning form to alert court, escort and prison staff to his risk.

25. At 3.45pm, the healthcare support worker uploaded the warning form to Mr Chumber-Kelly's electronic medical record. Minutes later, she emailed HMP Pentonville's mental health team generic email address, highlighting his risk. There is no evidence that this email was picked up and actioned by anyone in the mental health team. At interview, the Head of Healthcare, told us that there was also an expectation that PCLDS staff phone the prison's mental health team to pass on high risk information but this did not happen.

26. At 4.20pm, Mr Chumber-Kelly arrived at Pentonville and a Supervising Officer (SO) booked him in. The SO signed to say that he had reviewed the digital Person Escort Record (PER which accompanies prisoners on all journeys between police stations, courts and prisons to communicate risk factors) and there was nothing to indicate a risk of suicide or self-harm. However, the PER noted that Mr Chumber-Kelly had a suicide and self-harm warning in place and a history of depression and self-harm in prison.

27. At 4.54pm, an officer recorded in Mr Chumber-Kelly's electronic prison record that she had conducted his first night interview. She noted that he told her that he had been to Pentonville before, around five years previously, and although he appeared to be detoxing, he answered most of her questions. There is no evidence that staff gave him a prison phone account so he could call his family.

28. At 4.56pm, a nurse completed Mr Chumber-Kelly's initial reception health screen and noted that he had not reported any thoughts of suicide or self-harm. There is no record that the nurse saw the PER or suicide and self-harm warning form and no one from the mental health team had read the warning email from the healthcare support worker. A nurse noted that Mr Chumber-Kelly reported a history of self-harm, depression, personality disorder and illicit drug use. The nurse tested Mr Chumber-Kelly's urine for illicit drugs and completed a clinical opiate withdrawal scale (COWS) assessment, scoring Mr Chumber-Kelly 12 (mild withdrawal). He also referred him to the health and wellbeing team meeting (a multidisciplinary meeting that screens prisoners to identify what support services they may need).

29. At 5.34pm, prison staff moved Mr Chumber-Kelly to a shared cell on A Wing which, at the time, was the prison's early days in custody unit.

30. At 6.01pm, a GP, reviewed Mr Chumber-Kelly's drug test result and noted that he had tested positive for cocaine, opiates and cannabis. He prescribed several medications, including metoclopramide (to treat nausea and vomiting) and methadone (to treat opiate withdrawal).

14 July

31. At around 8.27am, a nurse who was, a non-medical prescriber, reviewed Mr Chumber-Kelly and recorded that he had described his mood as "good" and denied thoughts of suicide or self-harm. She completed a COWS assessment and scored him 16 (moderate withdrawal risk). She agreed to increase his dose of methadone slowly and referred him to the prison's substance misuse team.

32. At 9.34am, a pharmacy technician, reviewed Mr Chumber-Kelly's summary care record (a national electronic database that holds important patient information) and confirmed that, in the community, Mr Kelly was prescribed mirtazapine (an antidepressant). The nurse subsequently prescribed the medication.

33. At 11.32am, a nurse recorded that staff discussed Mr Chumber-Kelly at a health and wellbeing team referrals meeting. Attendees agreed to offer him psychological therapy, group work and substance misuse intervention. No one from the mental health team attended, although they were supposed to. There is also no record that the staff present at the meeting had any knowledge of the concerns outlined in the suicide and self-harm warning form, PER and email from the healthcare support worker.

34. At 11.30am, Mr Chumber-Kelly pressed his emergency call bell. An officer responded and saw that he had made a cut to his left arm, using a broken mirror. She asked for assistance and healthcare staff attended.A prison paramedic, recorded in Mr Chumber-Kelly's medical record that two nurses were tending to Mr Chumber-Kelly when he arrived and that he said he had cut himself out of frustration as he was unable to phone his family to tell them he was in prison.

35. At 11.39am, Mr Kelly was moved to a shared cell on F Wing, which, at the time, was the prison's integrated drug treatment system unit.

36. At 11.47am, an officer started suicide and self-harm monitoring procedures, known as ACCT. She noted that Mr Kelly had cut his left arm with a broken mirror but did not provide any additional information.

37. A short while later, an officer **conducted** Mr Chumber-Kelly's ACCT assessment. He noted that Mr Chumber-Kelly said it was his first time in prison for five years, he was terrified about the prospect of receiving a long sentence, was worried about his partner not knowing where he was and that his children may be taken into care. He also recorded that Mr Chumber-Kelly had a history of suicidal thoughts and self-harm. There is no evidence that the officer knew any of the risk information in Mr Chumber-Kelly's PER, suicide and self-harm warning form or the email to the mental health team.

38. At 1.55pm, the officer noted that he had phoned Mr Chumber-Kelly's partner to tell her that he was in prison but did not get an answer. At interview, he told the

investigator that he subsequently phoned Mr Chumber-Kelly's father and allowed Mr Chumber-Kelly to speak to him and let him know he was at Pentonville.

39. At 2.08pm, a SO completed an ACCT immediate action plan. (Prison Service policy states that the immediate action plan should be completed within one hour of the concern form being completed and before the ACCT assessment.) He recorded 'yes' next to the questions: 'Would a call to family or friends help?' and 'Do they have phone credit?' Mr Chumber-Kelly did not have any phone credit.

15 and 16 July

40. At 11.30am on 15 July, a SO conducted a first ACCT case review and noted that the paramedic attended. However, the paramedic told the investigator that he did not attend or contribute to the review. The SO recorded that Mr Chumber-Kelly said he harmed himself because he was not given a prison phone account or welfare call before he was moved to F Wing but that he felt better as he had since been in contact with his family and solicitor (according to records provided, Mr Chumber-Kelly did not have a prison phone account set up before he died and so we do not know if or how he called his solicitor). He added that Mr Chumber-Kelly did not report any thoughts of suicide or self-harm but he decided to continue ACCT monitoring, with an observation requirement of one an hour. He scheduled a review for 24 July but did not add any actions to the care plan. Again, there is no evidence that the ACCT review was informed by information on the PER or in Mr Chumber-Kelly's medical record.

41. At 12.32pm, prison phone records show that Mr Kelly dialled for a balance request and was notified that he had no money on his account.

42. On 16 July, in the morning record of conversation section of the ACCT document, An officer noted that Mr Chumber-Kelly said he was upset as he did not believe he should be in prison. In the afternoon summary section, staff noted that Mr Chumber-Kelly left his cell for association and interacted with other prisoners.

Events of 17 July

43. Shortly after starting work at around 6.45am, a SO, who was tasked with managing F Wing, told the investigator that he found out he had only four officers detailed to work on the wing instead of nine. He said this was due to staff shortages and, in line with the regime management plan, the wing was placed on lockdown meaning that staff only unlocked prisoners for controlled medication and healthcare appointments.

44. Mr Chumber-Kelly's cellmate, said in his police statement that he woke up to the sound of abnormal breathing between 7.00am and 9.00am. He said that he saw Mr Chumber-Kelly standing on top of the pipes at back of the cell with a ligature around his neck and attached to the window bars. He said that he asked Mr Chumber-Kelly, "What are you doing, stupid?" Mr Chumber-Kelly told him that he was worried about getting a sentence of eight to ten years. The cellmate said that they spoke for 30 to 45 minutes and that Mr Chumber-Kelly seemed a lot calmer afterwards. He added that he did not report it to staff as similar things happened all the time in prison. He said that the ligature remained attached to the window bars.

45. At around 10.30am, an officer unlocked Mr Chumber-Kelly so that he could go to a substance misuse review. A nurse increased his methadone prescription and noted that he did not report any thoughts of suicide or self-harm. When Mr Chumber-Kelly returned, a SO locked him in his cell. At interview, he said that he remembered Mr Chumber-Kelly looking a bit down but did not think too much of it as it was a detoxification wing and lots of prisoners looked down when stopping using drugs.

46. At 11.33am, an officer conducted an ACCT check and spoke to Mr Chumber-Kelly. In the record of morning conversation section of the ACCT, she recorded that he was due to have a bail hearing and was still waiting for staff to apply his phone credit. At interview, she added that he also told her that he got emergency phone credit in reception but another prisoner had used it (we have not been able to corroborate this information).

47. At around 12.00pm, the officer conducted a roll check. At interview, he told us that he saw Mr Chumber-Kelly sitting on a chair in the corner of the cell. He added that there was nothing unusual about him and nothing was attached to the window.

48. The cellmate said in his police statement that he woke up at about 12.30pm and saw Mr Chumber-Kelly hanging from a ligature. He said that he asked Mr Chumber-Kelly if he was okay but did not get a response. He then tried to lift him up before lowering him down gently and pressing the cell's emergency call bell.

49. At 12.34pm, cell bell records show that Mr Chumber-Kelly's cell bell activated. At 12.35pm, an officer made her way to the cell and looked through the observation panel on the cell door. She saw Mr Chumber-Kelly hanging by a ligature attached to the window. At 12.37pm, she radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties and instructs staff in the control room to call for an ambulance), before going into the cell and cutting the ligature. (She gave her location as the third floor but Mr Chumber-Kelly's cell was on the second floor.)

50. Shortly afterwards, and an officer arrived. They helped to lie Mr Kelly on the ground but while doing so, saw that one of his legs was stuck behind the pipes at the back of the cell. They did not start cardiopulmonary resuscitation (CPR) and waited for healthcare staff to arrive.

51. In the meantime, a nurse, who was already on the third floor, made her way to the landing. She could not see anyone, so she radioed for clarification and staff told her that the incident was on the second floor. At interview, she told us that as she made her way to Mr Chumber-Kelly's cell, she came across an officer walking along the landing with a prisoner (his cellmate). She said that she asked the prisoner if he was okay and that the officer replied, saying, "He's fine". Assuming, in error, that the code blue was for that prisoner, she radioed the control room and asked them to cancel the code blue.

52. A nurse told us that she noticed that officers continued to gather outside Mr Chumber-Kelly's cell and she made her way there. When she arrived at 12.41pm, she saw Mr Chumber-Kelly on the floor and reinstated the code blue. She said that she asked officers to move him out of the cell but his leg remained stuck behind the pipes. She established an airway and started CPR at 12.42pm. At 12.44pm, staff manged to free his leg and moved him onto the landing for easier access.

53. The prison's ambulance order form shows that an ambulance arrived at the prison at 12.47pm, and that paramedics reached Mr Chumber-Kelly at 12.50pm. Paramedics led resuscitation efforts, supported by prison and healthcare staff. At 1.31pm, paramedics took Mr Chumber-Kelly to University College Hospital, London. At 1.57pm, a hospital doctor pronounced life extinct.

Contact with Mr Chumber-Kelly's family

54. At 1.57pm, the prison appointed a safer custody hub manager, as the family liaison officer (FLO). At 2.45pm, the FLO established that Mr Chumber-Kelly had identified his partner as his next of kin, but following police checks, it was deemed unsuitable for staff to visit her address.

55. At 3.00pm, the FLO recorded that Mr Chumber-Kelly had recently spoken to his father on the phone and his address was assessed as suitable to visit. As he lived in Suffolk, the Head of Safer Custody asked HMP Highdown (which was geographically closer) if they could send a family liaison officer but they were unable to assist. At 4.00pm, , the prison's police liaison officer contacted Suffolk Police to ask for assistance. It is unknown when or whether they responded to her request.

56. At 5.45pm, the FLO spoke to the then Governor, who agreed that they could break the news by phone to avoid the family finding out from other sources. At 6.00pm, She phoned Mr Chumber-Kelly's father and broke the news. She confirmed that he had support and arranged to visit him the following day. She also notified Mr Chumber-Kelly's partner.

57. On 18 July, the FLO and an officer visited Mr Chumber-Kelly's father at his home address to offer support and explain the next steps.

58. On 19 July, the FLO contacted Mr Chumber-Kelly's mother following a request from his partner. They spoke at length and she offered support.

59. The FLO continued to offer support to Mr Chumber-Kelly's family until his funeral, which took place on 15 August. The prison contributed towards the cost of the funeral in line with national policy**.**

Support for prisoners and staff

60. After Mr Chumber-Kelly's death, the 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.

61. The prison posted notices informing other prisoners of Mr Chumber-Kelly's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Chumber-Kelly's death.

Post-mortem report

62. A post-mortem examination confirmed that Mr Chumber-Kelly died of suspension. Toxicology tests found therapeutic levels of mirtazapine and methadone, low levels

of morphine (possibly linked to non-recent heroin use) and cannabis. The toxicologist was unable to determine when Mr Chumber-Kelly used cannabis but noted that it could persist in the body for a considerable length of time.

Events after Mr Kelly's death

63. On 18 July, police officers searched Mr Chumber-Kelly's cell and found a note tucked in a book that his cellmate confirmed he had not written. In the note, Mr Chumber-Kelly said that he was stuck in his cell with no food, no cigarettes and no drugs. He said that he had been trying to go to church to pray but staff would not let him because the wing was locked down. He added that he needed to see his friend as he owed him money.

Findings

Assessing and managing the risk of suicide and self-harm

64. PSI 64/2011, which governed suicide and self-harm prevention procedures at the time of Mr Chumber-Kelly's death (since replaced by the Prison Safety Policy Framework), required all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Despite recorded information, staff at Pentonville failed to identify that Mr Chumber-Kelly was at risk when he arrived and did not begin ACCT procedures to support him. They later began ACCT procedures when he harmed himself but we have some concerns about the management of the process.

Reception screening

65. Mr Chumber-Kelly had significant risk factors for suicide and self-harm when he arrived at Pentonville. He had not been in prison for five years. He was charged with serious offences, he was likely to receive a long sentence if found guilty and he was worried about what would happen to his children. He had a history of substance misuse, depression, suicide attempts and self-harm and had said he would kill himself if he went to prison. Evidence tells us that prisoners are also at increased risk of suicide and self-harm in their first days in custody.

66. Although Mr Chumber-Kelly's PER and suicide and self-harm warning form clearly highlighted these risk factors, a SO signed to say that Mr Chumber-Kelly did not have any suicide or self-harm markers and we conclude that he did not properly review the documents.

67. The prison could not provide us with a copy of the first night centre documentation so we could not confirm its completion. An officer's entry in Mr Chumber-Kelly's prison record indicates that a first night interview was conducted but there was no reference to Mr Chumber-Kelly's risk of suicide or self-harm, or to information in the suicide and self-harm warning form or PER.

68. A nurse did not assess Mr Chumber-Kelly as presenting a risk of suicide or self-harm. He told the investigator that he routinely checked the relevant part of a prisoner's medical record but did not recall seeing a suicide and self-harm warning form. He also said that he did not see the PER as it was digitised and there was an ongoing issue with healthcare staff not having access to them. Although PCLDS colleagues had emailed the mental health team in advance of Mr Chumber-Kelly's arrival to alert them to his risk, there is no evidence that anyone had read the email or taken any action to share the information.

69. The process for identifying Mr Chumber-Kelly's risk before he arrived at Pentonville worked well, however, evident weaknesses in the reception process meant that staff assessing him when he arrived in prison missed the information. Had they seen it, they might have begun ACCT procedures at an earlier stage.

70. We asked the prison whether there were processes in place to ensure that reception staff did not miss relevant risk information in the PER and any suicide and

self-harm warning form. They explained the current process but we are not convinced that it is sufficiently robust. We make the following recommendation:

The Governor and Head of Healthcare should review the training for reception and induction staff to ensure they understand how to identify prisoners at risk of suicide and self-harm, including that all relevant risk information, including the PER, is properly shared and examined as part of the reception/first night process.

ACCT procedures from 14 July

71. On 14 July, Mr Chumber-Kelly made a cut to his arm and staff began ACCT procedures. Mr Chumber-Kelly was still subject to ACCT procedures when he died.

72. Generally, we found Mr Chumber-Kelly's ACCT to contain little detail or information to help staff assess the severity of his risk or record how they planned to support him. The record of assessment did not record sufficient detail about the nature of Mr Chumber-Kelly's concerns or background information about his risk (other than that he had not been in prison for five years). Despite Mr Chumber-Kelly only having been at Pentonville for one day when ACCT procedures were started, there is no evidence that staff referred to the PER, suicide and self-harm warning form or gathered relevant information from his medical record.

73. No one from the healthcare team attended Mr Chumber-Kelly's first ACCT review, contrary to national policy, and a SO did not note any support actions in the care plan. A SO set the observation level at one an hour, and broadly, staff conducted the checks appropriately.

74. Overall, we consider that the ACCT procedures provided a superficial level of support to Mr Chumber-Kelly, perhaps appropriate to the risk apparently presented by his behaviour and presentation on 14 July but not when the information about the severity of his risk noted in the PER, suicide and self-harm warning form and email from PCLDS are considered.

75. Several staff involved in Mr Chumber-Kelly's ACCT told us that time pressures and staff shortages had negatively impacted their ability to complete the ACCT processes properly.

76. The then Head of Safety, told us that he had implemented a quality assurance process to drive up the quality of ACCT procedures at Pentonville. Clearly, there were issues with the quality of Mr Chumber-Kelly's ACCT. The Governor will want to consider whether the existing quality assurance process is robust enough to have identified and addressed these issues.

Prison phone access

77. Mr Chumber-Kelly did not use his prison phone account to make a phone call after he arrived at Pentonville (although staff facilitated one call to his father). PSI 07/2015 on early days in custody requires that newly arrived prisoners are given access to a phone to contact their legal advisor or to tell their family where they are being held. PSI 49/2011 on prisoner communication services states that governors

must have local arrangements in place to allow a call to be made in the first 24 hours.

78. A SO told the investigator that staff on A Wing issue the pre-funded reception phone accounts to enable swift family contact, but Mr Chumber-Kelly was moved to F Wing before that could happen. There is no evidence that Mr Chumber-Kelly received an induction or signed a prison phone terms and conditions form. The Head of Safety told us that as Mr Chumber-Kelly arrived on a Friday, his induction would have started on the following Monday. The SO also told us that the prison phone allocation process would have been delayed regardless, as the administrators who set up the accounts do not work at weekends (15 to 16 July was a weekend).

79. In the absence of reception or first night records (as the prison told us they could not locate them), the investigator was unable to confirm the information an officer recorded that Mr Chumber-Kelly was given a phone account in reception.

80. Mr Chumber-Kelly told staff that not being able to speak to his family was a source of frustration and upset. Being in prison can be overwhelming and family connections provide a sense of normalcy that can help to reduce feelings of fear and anxiety.

81. Evidence tells us that the early days and weeks in prison increase the risk of suicide and self-harm. We are concerned that in too many prisons, the creation of prison phone accounts to allow prisoners to call family and friends quickly after their arrival is not sufficiently prioritised and relies on staff who work Monday to Friday. That such an important mitigative step is not put in place because it is the weekend is simply unacceptable. We consider this to be a national problem requiring attention from the most senior leaders in HMPPS. We make the following recommendation:

The Director General of HMPPS should review the current process for and priority given to setting up prison phone accounts for newly arrived prisoners (both from court and on transfer) to ensure that they can call family and friends without delay.

Clinical care

82. The clinical reviewer found that the care Mr Chumber-Kelly received at Pentonville was not equivalent to that which he could have expected in the community.

83. Prison mental health staff did not review or action the email sent by the healthcare support worker on 13 July which provided further information about the extent of his risk. There is no evidence that the healthcare support worker also phoned the mental health team, which, the Head of Healthcare, told us was part of the agreed process. Had healthcare staff reviewed the email from the healthcare support worker, it is possible that staff would have begun ACCT procedures earlier. The Head of Healthcare told us that she was reviewing the community pathway with the local PCLDS team and had implemented a rota for checking the mental health team's generic email inbox three times a day. We therefore do not make a recommendation about this.

84. A member of the mental health team did not attend the health and wellbeing team's referrals meeting on 14 July, as required. The clinical reviewer established that this prevented discussion about the risk information from the suicide and self-harm warning form, the PER and PCLDS. The Head of Healthcare told us that she had arranged supportive supervision for the nurse who did not attend. The Head of Healthcare will nonetheless need to address the clinical reviewer's recommendation that a member the mental health team attends every referral meeting for the health and wellbeing team and that relevant records are screened beforehand.

85. Healthcare staff did not demonstrate enough professional curiosity when assessing Mr Chumber-Kelly's risk and relied on him denying thoughts of suicide and self-harm. The clinical reviewer considered that healthcare staff would have benefitted from using a risk formulation approach to manage Mr Chumber-Kelly's risk and to supplement ACCT procedures, in line with NICE guidelines for assessing self-harm. She made a recommendation about this which the Head of Healthcare will want to address.

Emergency response

86. The body worn video camera footage of the emergency response showed a chaotic scene, with staff shouting at each other. No single person led resuscitation efforts. A nurse told us that on reflection, the shouting was not necessary but attributed it to the shock of finding Mr Chumber-Kelly and the stress of not being able to free his leg from behind the pipe.

87. The paramedics' ambulance log noted that there was no obvious leadership before their arrival and the scene was chaotic, with staff presenting as 'flustered'. The clinical reviewer considered that while the quality of the CPR provided was satisfactory, the lack of leadership and the chaotic scene were concerning. While we recognise the distressing nature of finding a prisoner hanging, healthcare staff are responsible for taking the lead during an emergency response and communication should be clear and concise. We make the following recommendation;

    The Head of Healthcare should ensure that healthcare staff are fully prepared to effectively manage emergency response situations.

Governor and Head of Healthcare to note

Response following medical emergency code

88. The emergency response when Mr Chumber-Kelly was found hanged suffered from unfortunate human errors. An officer responded promptly when she found Mr Chumber-Kelly hanged and appropriately called a code blue but gave the wrong landing location. As a result, a nurse initially went to the wrong cell.

89. The nurse then cancelled the code blue (and therefore the ambulance request) in error when she wrongly assumed that the prisoner being escorted away from the cell was the patient, and considered it was no longer a medical emergency. This caused a delay of around seven minutes before control room staff called an ambulance after the nurse reached Mr Chumber-Kelly's cell and reinstated the code blue.

90. Prison staff waited for healthcare staff to attend to start CPR. This caused a delay of around seven minutes. A told the investigator that he simply froze and in retrospect, knew that he should have started CPR.

91. We do not consider that there is any recommendation we could make in these circumstances, but the Governor will wish to consider whether there is any broader learning about staff's preparedness for medical emergencies.

Inquest

92. At the inquest, which took place on between 19 and 30 January 2026, the Coroner concluded that Mr Chumber-Kelly took his own life.

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