

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rickie Poon, a prisoner at HMP Pentonville, on 13 March 2025

A report by the Prisons and Probation Ombudsman

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

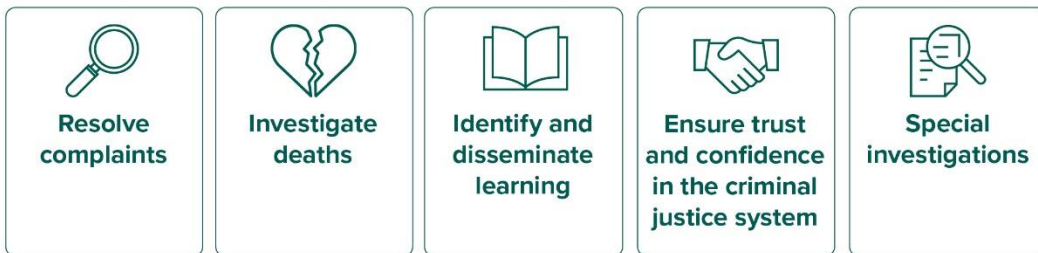
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

OUR VISION

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

WHAT WE DO



WHAT WE VALUE



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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 Rickie Poon was found hanged in his cell on 13 March 2025 at HMP Pentonville. He was 38 years old. I offer my condolences to Mr Poon's family and friends.

Mr Poon died a month 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. While it is positive that suicide and self-harm support procedures (known as ACCT) began in reception, the subsequent ACCT monitoring was poor. ACCT reviews were not always multidisciplinary, and staff relied too heavily on Mr Poon's presentation. This meant that they misjudged his risk of suicide and self-harm. Our investigation into a previous self-inflicted death at Pentonville in 2023 identified concerns with ACCT management and staff misjudging the risk of suicide and self-harm. It is disappointing that we found similar issues in this investigation. We also found that the frequency of ACCT checks on Mr Poon was reduced too quickly, and the ACCT was closed prematurely. I am concerned that pages of Mr Poon's ACCT document remain missing and Pentonville have been unable to explain their absence.

Mr Poon did not receive an induction or basic skills assessment. He did not have access to purposeful activity which meant he spent most of his time in his cell.

When Mr Poon appeared at magistrates' court on 13 February, magistrates noted that part of their consideration for remanding him to prison was for his own protection following a recent suicide attempt after he had been charged with offences. Prisons are very rarely, and almost certainly not in the current capacity pressures, places of safety for people with serious mental ill health or who are deemed at serious risk of suicide.

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

April 2026

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Summary

Events

1. On 13 February, Mr Rickie Poon was remanded into custody at HMP Pentonville, charged with sex offences.
2. Mr Poon was a former police officer and had attempted suicide less than a month earlier which resulted in him being detained in a mental health hospital. Court staff documented their concerns that Mr Poon's risk of suicide and self-harm was high and shared them with reception staff at Pentonville. During his reception interviews, Mr Poon presented as calm and denied wanting to kill himself. However, a nurse began ACCT procedures due to other factors which he considered heightened Mr Poon's risk of suicide and self-harm.
3. Mr Poon was managed as a vulnerable prisoner and moved from reception to the vulnerable prisoners' wing (where prisoners identified as vulnerable are kept separate from the main prison population). He did not receive an induction or basic skills assessment (which determines work allocation).
4. Staff were initially required to check Mr Poon once an hour and the frequency of checks was reduced the following afternoon. Three days later, the safer custody team emailed the three supervising officers of C Wing and D Wing, where Mr Poon lived. They asked for the frequency of checks be increased back to once an hour as they had received information which indicated Mr Poon's risk of suicide was high. Two supervising officers could not remember seeing the email, while another recalled seeing it but did not take any action.
5. Mr Poon engaged in ACCT reviews on 14, 21 and 28 February (when the ACCT was closed). He consistently denied thoughts of suicide and self-harm. Staff considered that he presented as calm and well and said they felt like they were talking to a colleague at times. An ACCT post-closure review took place on 8 March 2025, which concluded that Mr Poon did not pose an imminent risk as he denied thoughts of suicide and self-harm.
6. At around 5.28am on 13 March, during a routine wing welfare check, an officer saw Mr Poon hanging in his cell. Nurses and other prison staff arrived quickly and noticed that Mr Poon's body was stiff and he looked blue. They began cardiopulmonary resuscitation. Paramedics arrived at 5.41am and at 5.48am, they declared life extinct.

Findings

7. Mr Poon had significant risk factors that indicated he was at heightened risk of suicide. Overall, we found that the prison failed to adequately assess and address these risks.
8. Staff in reception appropriately began ACCT procedures in reception. The nurse carefully considered all of Mr Poon's risk factors and did not rely on his presentation alone.

9. During the initial assessment, ACCT case reviews and general interactions with staff, Mr Poon consistently presented as calm and denied thoughts of suicide or self-harm. His lack of a diagnosed mental illness and his calm presentation were interpreted as evidence that he did not pose a risk of suicide, despite the objective evidence to the contrary. We found that staff lacked professional curiosity, had a poor understanding of suicide and self-harm risk and relied too much on Mr Poon's presentation. This led to decision-making which was ill-informed and compounded by the absence of a multidisciplinary approach that included clinical oversight.
10. An email which the safer custody team sent the supervising officers on D Wing was not actioned.
11. ACCT welfare checks were reduced too quickly (less than 24 hours after Mr Poon arrived). His risk of suicide was consistently under-estimated and even when he was considered at high risk of suicide, staff were never required to check him more than once an hour. His care plan was insufficient to manage his risk and there was a lack of recognition that many of Mr Poon's risk factors could not be mitigated. ACCT case management was inconsistent, and Mr Poon's ACCT was closed prematurely.
12. We are concerned that pages of Mr Poon's ACCT remain missing.
13. Mr Poon said he felt lonely and bored at times. He spent most of his time in his cell. In the week leading up to Mr Poon's death, the prison did not provide him with a full regime. While there were days when some activities and other services were running, Mr Poon was unable to access them due to the lack of assessment and induction.
14. Vulnerable prisoners who are taken straight to the Vulnerable Prisoners' Wing from reception do not always receive a timely induction and a basic skills assessment. Prisoners on other locations are offered the opportunity to engage in induction the day after they arrive; induction on the Vulnerable Prisoners' Wing is offered once a week. Although staff offered Mr Poon interim support (through other prisoners), there is no evidence that he received a full induction or basic skills assessment.

Recommendations

- **The Governor should ensure that there is a robust and effective quality assurance process in place to monitor the quality of ACCT management, focusing particularly on staff:**
 - **identifying prisoners' objective risk factors and basing assessment of risk on them;**
 - **setting meaningful and tailored care plan actions; and**
 - **completing and properly securing all ACCT documentation.**
- **The Governor should ensure that prisoners located on the Vulnerable Prisoners' Wing receive a full induction, including a basic skills assessment, within the first five days in custody, in line with PSI 07/2015.**

The Investigation Process

15. HMPPS notified us of Mr Poon's death on 13 March 2025.
16. 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.
17. The investigator visited Pentonville on 18 March 2025. She obtained copies of relevant extracts from Mr Poon's prison and medical records. She interviewed two prisoners.
18. The investigator interviewed 10 members of staff and one prisoner at Pentonville on 8 and 27 May. The investigator interviewed one member of staff in July.
19. NHS England commissioned a clinical reviewer to review Mr Poon's clinical care at the prison. Ms Macey and the investigator jointly interviewed healthcare and prison staff.
20. We informed HM Coroner for London Inner North of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
21. The Ombudsman's office contacted Mr Poon's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He was concerned that staff stopped ACCT monitoring for Mr Poon less than a month after he arrived at Pentonville, despite mental health professionals having identified his risk of suicide as extremely high. He was also concerned that after contact with nurses in reception, no further mental health support appeared to have been put in place.
22. Mr Poon's brother asked the following questions:
 - What was the actual time of Mr Poon's death?
 - What plan was in place to protect Mr Poon from harming himself?
 - How frequently was Mr Poon checked?
 - During a social visit on 25 February 2025, he noticed Mr Poon had marks on his neck. Were they documented by staff?
23. We have tried to address these questions in this report. However, we are unable to say exactly when Mr Poon died.
24. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.
25. Mr Poon's family received a copy of the draft report. The solicitor representing Mr Poon's family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have addressed these in separate correspondence.

Background Information

HMP Pentonville

26. HMP Pentonville is a local prison in London that primarily serves the courts of north and east London. Practice Plus Group, in partnership with North London NHS Foundation Trust, provides healthcare services.

HM Inspectorate of Prisons

27. The most recent full inspection of HMP Pentonville was in June and July 2025. The full report is not yet available but a debriefing paper detailed initial findings. Inspectors found that the care and support offered to new prisoners during their first few days in prison was wholly inadequate. They found clear shortcomings in the oversight of the first night and induction process and many prisoners experienced a chaotic and frightening first few days at Pentonville as a result.
28. Inspectors found that the number of recorded self-harm incidents was similar to the previous inspection and remained lower than other reception prisons. However, only 37% of prisoners who had been on an ACCT said they felt cared for. Staff had very limited knowledge of prisoners in their care or why they were on an ACCT, including those under constant supervision. Inspectors observed a widespread lack of support for prisoners at imminent risk of self-harm, many of whom lived in squalid conditions. There had been four heads of safety in the previous two years, and they had not addressed the poor care for prisoners at risk of suicide or self-harm.
29. Inspectors concluded there were substantial weaknesses in the ACCT case management documents. Inspectors found that Pentonville did not always respond to PPO recommendations, and one PPO report had not been addressed at all. In addition, investigations into serious incidents of self-harm were not always carried out. They found that the prison had not addressed deficiencies identified repeatedly in internal and PPO investigations.
30. Following the inspection, HM Chief Inspector issued an Urgent Notification, a process which allows him to alert the Lord Chancellor if he has an urgent and significant concern about the performance of a prison. He identified that the governor needed significant support and investment from HMPPS, including strengthening his senior team, to make measurable improvements in the future.

Independent Monitoring Board

31. 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 some positive improvements in both reception and early days in custody. They found that on arrival in reception, all relevant checks, processes and assessments were in place and the IMB had observed a high level of professionalism and care from staff and peer mentors.

32. The IMB found that incidents of self-harm had increased by 13% compared to the previous year but there were no identifiable themes behind this. They further reported that inadequate completion of ACCT documentation remained an issue, with important elements regularly not completed and insufficient evidence of meaningful conversations. There was a detailed ACCT documentation audit process in place, but the relevant checks were not consistent, and the IMB had not seen any noticeable improvement in the quality of ACCT documentation.

Previous deaths at HMP Pentonville

33. Mr Poon was the seventh prisoner to die at Pentonville since March 2022. Of the previous deaths, three were self-inflicted, two were due to natural causes and two were drug-related. Our investigation into a self-inflicted death in 2023 identified concerns with ACCT management and staff misjudging the risk of suicide and self-harm.
34. Since Mr Poon's death up until the end of July 2025, two prisoners have died at Pentonville. One was due to an unknown cause. This remains under investigation. The other prisoner apparently took his own life. There are no similarities between the findings in that investigation and those following our investigation into Mr Poon's death.

Assessment, Care in Custody and Teamwork

35. HMPPS' Prison Safety Policy Framework sets out the mandatory requirements for staff on identifying risks of suicide and self-harm and supporting those at risk to reduce harm. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service case management approach used to support prisoners identified at risk of suicide and self-harm. The framework states that all staff have responsibility for ensuring that an ACCT is opened if they believe a prisoner is 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. There should be regular multidisciplinary review meetings involving the prisoner.

Early days in custody and induction

36. As part of the early days in custody process, prisoners receive an induction to the prison. Prisoners are given information about the prison regime, behaviour expectations, facilities and how to access support. Basic skills assessments take place and help identify suitable education and employment activities. Prison Service Instruction (PSI) 07/2015 on Early Days in Custody sets out expectations about when and how inductions should take place.

Key Events

Background

37. In December 2024, Mr Rickie Poon, a serving police officer, was arrested on suspicion of two sex offences and given bail. He was suspended from his job pending criminal and internal gross misconduct investigations. Mr Poon had no recorded history of suicide attempts or self-harm. He had no documented history of mental illness or substance use issues.
38. On 19 January 2025, Mr Poon checked into a hotel in London and took an overdose of prescription and over the counter medications. The following morning, hotel staff telephoned the police as they saw Mr Poon acting strangely in the reception area and were concerned for his welfare. Police arrived and took Mr Poon to hospital.
39. Five typed letters, signed by Mr Poon and dated 19 January, were found. They set out his plan to kill himself and included extensive information to enable his brother to manage his financial affairs.
40. On 23 January, Mr Poon was detained under Section 2 of the Mental Health Act (which allows compulsory detention of individuals for assessment of their mental health for up to 28 days) and admitted to Chase Farm Psychiatric Hospital.
41. On 24 January, following an accelerated misconduct hearing, Mr Poon was dismissed from the police service.
42. On 12 February, Mr Poon was discharged from Chase Farm. A psychiatrist, in consultation with the Inpatient Clinical Director, wrote a discharge summary of Mr Poon's acute admission. They found no evidence of acute mental illness that warranted ongoing admission to an acute ward, and Mr Poon did not meet the criteria for further detention under the Mental Health Act.
43. They assessed that it was clear that Mr Poon viewed attempting suicide as a rational and logical choice. Mr Poon told doctors that he could not guarantee that he would not try to end his life again, but said he would never do this in the family home due to the distress that would ensue and that he would be under his family's close watch. The doctors concluded that due to several risk factors, including the degree of planning of his suicide attempt, his profession and ongoing investigation, Mr Poon's risk of suicide remained high in the community and prison. The psychiatrist recommended that if Mr Poon went to prison, he should be flagged to the in-reach mental health team. He offered to liaise with them directly.

HMP Pentonville

44. On 13 February, Mr Poon appeared at court, charged with sex offences. He was remanded into custody and taken to HMP Pentonville. It was Mr Poon's first time in prison.
45. At 3.20pm, a court custody manager completed a suicide and self-harm warning form. She documented that the court's police liaison officer had raised concerns

about Mr Poon's demeanour and behaviour, and she had been advised he was at high risk of suicide and would harm himself at the earliest opportunity. She noted he was to be kept on "five-minute constant watch [sic] whilst in custody" (which we have taken to mean that he was being checked every five minutes) and advised that Mr Poon should be prioritised.

46. At 5.09pm, a Serco prison escort and custody officer documented in Mr Poon's digital person escort record (DPER, which contains information about a prisoner's risk, offence, health and property) that Mr Poon had tried to kill himself on 19 January by overdose and had said he would try again when given the opportunity. A court warrant supplement (which provides additional information about prisoners) set out that Mr Poon had risk and vulnerability factors as he had attempted suicide and expressed an intention to try again.
47. Mr Poon arrived at Pentonville at 5.20pm. At 5.21pm, a Serco officer (whose signature is illegible) completed a First Night Centre priority process form which incorrectly recorded that it was not Mr Poon's first time in prison and that he had no suicide or self-harm warnings.
48. At an unrecorded time, an officer interviewed Mr Poon in reception. He told the investigator that he was told Mr Poon had a history of self-harm but did not recall necessarily knowing the recent time frame. He said he would ordinarily receive a 'court log' from Serco (which details prisoners' care and any concerns during their time at court and transfer to prison) and other relevant documents such as a warrant. He could not remember if he had seen the suicide and self-harm warning form, the DPER or which documents were available to him.
49. The officer said he spoke to Mr Poon for between five and ten minutes, and the main purpose was to complete the cell sharing risk assessment (CSRA). The officer said that Mr Poon presented in a fairly upbeat manner. He thought Mr Poon was 'okay' and did not seem that low in mood. Mr Poon denied thoughts of suicide and self-harm. The officer told him how to access support from Listeners (prisoners trained by the Samaritans to support other prisoners in crisis) and how to access the Samaritans by phone.
50. The officer later documented in Mr Poon's electronic prison record that it was his first time in prison. Due to Mr Poon's previous profession and the nature of the alleged offences, the officer identified Mr Poon as vulnerable to threats and attack from prisoners. He completed his CSRA and assessed him as high risk (which meant he could not share a cell with other prisoners). The custodial manager (CM) authorised this. Mr Poon accepted a space on the Vulnerable Prisoners' Wing (where prisoners considered vulnerable for a variety of reasons, including the nature of any alleged offences, are kept separate from the general prison population to reduce the risk of bullying and violence).
51. At around 6.02pm, the nurse completed Mr Poon's initial health screen. He told the investigator that he remembered receiving an email (he could not recall who sent it) that a former police officer would arrive at Pentonville that evening. He was aware Mr Poon had tried to kill himself recently and had been sectioned. He said he read the DPER and noticed the suicide and self-harm warning.

52. The nurse told the investigator that Mr Poon appeared calm, polite and settled. He said there were no 'red flags' from his presentation and Mr Poon had denied thoughts of suicide or self-harm. Despite his presentation, the nurse said he opened an ACCT, based on his known risk factors. The nurse said he was surprised that officers had not already opened an ACCT but that happened often, and he thought this may be because some officers presumed it was not their job.
53. The nurse completed the ACCT concern form. He documented Mr Poon's suicide attempt, being detained under the Mental Health Act on 23 January, his previous profession and the nature of the charges against him as risk factors. The nurse referred Mr Poon to the early days in custody team for discussion the following morning.
54. At around 6.15pm, the supervising officer (SO) received Mr Poon's ACCT document from the nurse and completed the immediate action plan. He noted Mr Poon was to be in a single cell (in line with his CSRA) and reminded him how to access Listeners. At around 6.45pm, the SO facilitated a welfare telephone call to Mr Poon's brother and made a note that the mental health in-reach team should be invited to the first ACCT case review, in light of his recent admission to hospital.
55. The SO documented in Mr Poon's electronic prison record that this was Mr Poon's first time in prison, and he was apprehensive given his previous profession. The SO observed Mr Poon appeared calmer after being told he would not be sharing a cell with anyone. In discussing his suicide attempt, Mr Poon told the SO he was depressed at the allegations made. He said his head was not in the 'right place' but denied current thoughts of suicide and self-harm. The SO instructed staff to check Mr Poon once per hour, supported by three recorded conversations daily.
56. Shortly after 8.00pm, Mr Poon arrived on the Vulnerable Prisoner's Wing (D Wing).
57. At an unknown time the following morning, 14 February, the chaplain, who was an ACCT assessor, met Mr Poon to complete his initial ACCT assessment. The chaplain told the investigator that he checked Mr Poon's electronic prison record and intended to obtain information from other departments during the first case review which was due to happen after the assessment.
58. The chaplain told the investigator that the assessment was one of the easiest he had ever done. He described Mr Poon as friendly, intelligent, self-aware and able to give a good account of himself. Mr Poon spoke in detail about his previous suicide attempt. Mr Johnson told the investigator that the assessment stood out as unusual and he wondered why Mr Poon seemed so cheerful. He asked him about this, and Mr Poon told him it was because he knew the system and what was going to happen. He denied thoughts of suicide or self-harm.
59. At around 10.30am, Mr Poon attended his first ACCT case review. An SO chaired the multidisciplinary review which a safer custody practitioner for Practice Plus Group, and the chaplain also attended. Mr Poon talked about his recent suicide attempt which he said he was initially disappointed was not successful. However, he said these feelings were quickly replaced by hope as his family, specifically his brother and father, were very supportive, and he realised the impact his suicide attempt had had on them. During the review, the team identified triggers for the suicide attempt as his ongoing court case and dismissal from his employment. Mr

Poon's care plan reflected that it was his first time in prison, and he was upset due to the nature of the charges against him. His recent suicide attempt was not documented and the personal contribution form (where prisoners can document triggers and what support helps them to cope) was blank.

60. The review noted that Mr Poon had not been in prison before. Mr Poon told them he had not had an induction or basic skills assessment (which would allow him to access work, education and other activities) and was keen to engage in purposeful activity. The SO said he would email the activities department and ask an Insider (a trusted prisoner who helps other prisoners understand procedures in prison) to speak to him about the wing regime and to answer any questions.
61. The team observed that Mr Poon articulated his points clearly and showed no visible signs of distress. Mr Poon said he had no thoughts of suicide or self-harm as he wanted to be there for his family and did not want to die. Mr Poon asked to telephone his solicitor as his telephone numbers had not yet been cleared by the security team. The SO said he would facilitate a call between Mr Poon and his solicitor (which he did later that afternoon) and told Mr Poon he would facilitate another welfare call to his brother over the weekend if his numbers had not been cleared by then.
62. Care plan actions were set for the SO to facilitate welfare calls to Mr Poon's solicitor and family. Mr Poon was set actions to apply to add family telephone numbers to his prison phone account and to collect books and distraction materials. There was one joint action to ensure the basic skills assessment was completed. The ACCT remained open, with checks reduced to once every three hours, supported by two daily conversations. The SO told the investigator that despite Mr Poon being in prison for less than 24 hours, the team felt he was no longer in crisis, and he had convinced them that the suicide attempt was a temporary moment.
63. The SO told the investigator that the team agreed Mr Poon did not present with any 'glaring' risk, and they did not think he was in crisis anymore. However, they felt it appropriate to keep the ACCT open given his alleged offences, his previous employment and recent suicide attempt.
64. That day, a social worker from the mental health in-reach team, assessed Mr Poon as part of the early days in custody pathway. She told the investigator that Mr Poon was polite and friendly. She said that he appeared calm, and she did not observe any signs of distress. Mr Poon described his mood as "apprehensive" as the prison environment was new to him. He said he had not slept well the previous night but was confident that would improve once he felt more settled. Mr Poon told the social worker that an ACCT had been opened but repeatedly said that he was not feeling suicidal or thinking about harming himself. The social worker thought he seemed concerned about the label of "high suicide risk".
65. At 9.36am on 17 February, a liaison officer in the Offender Management Unit emailed the Safer Custody Team and the Head of Safety. The email said that information from the police suggested that, based on his recent suicide attempt and the psychiatrist's assessment at Chase Farm Hospital, Mr Poon remained at very high risk of suicide, and they believed he would attempt suicide again. The

liaison officer asked that the ACCT should be updated, checks increased to one an hour and the email shared with three senior officers who worked in the VP Wing.

66. At 10.37am, a Safer Custody administrator forwarded the email to three senior officers and asked that ACCT checks be increased to hourly. One of the senior officers told the investigator that he checked his emails daily but did not recall seeing this one. He said that if he had received an email of that nature, he would have asked staff to conduct a welfare check. There is no evidence that this was done.
67. Another senior officer told the investigator that he could not remember if he had seen the email or if he was working that day. He was sure either of the other two senior officers would have picked it up. The senior officer said that the Safer Custody Team usually telephoned the wing to follow up an email if they were concerned about a prisoner. There is no record that a telephone call took place.
68. A third senior officer told the investigator that he remembered reading the email on 17 or 18 February. He said he did not take action and noted that Mr Poon's ACCT case manager had been copied into the email. He said in similar situations, staff checked with each other that action had been taken, and the prisoner's ACCT case manager was aware. The senior officer could not recall speaking to the other senior officer and took no other action. The frequency of Mr Poon's ACCT checks remained once every two hours.
69. On 18 February, a consultant forensic psychiatrist, and a specialty doctor in psychiatry, discussed Mr Poon at the mental health team meeting. They discussed Mr Poon's circumstances, including his previous profession, being on remand for alleged sex offences and that he had recently been sectioned at Chase Farm Hospital following a suicide attempt. The team reviewed the social worker's assessment from 14 February, and noted Mr Poon did not have a diagnosis of a mental illness. They made a plan for Mr Poon's risk of suicide and self-harm to be managed through the ACCT process, and they agreed to review him at the next meeting, when they had received the discharge summary from Chase Farm Hospital. There is no evidence the plan was communicated to wing staff or the safer custody team.
70. At around 2.00pm on 21 February, Mr Poon attended his second ACCT review. A senior officer chaired the review and the chaplain attended. As Mr Poon was not under the care of the mental health team, staff from healthcare were not asked to attend. They noted that Mr Poon showed no signs of distress and denied thoughts of suicide or self-harm. He said he had a video call with his brother, but his telephone numbers had still not been cleared nor had he had his basic skills assessment. As this remained an outstanding action on Mr Poon's care plan, the review concluded the ACCT should remain open, with reduced checks of one each morning and afternoon, to be supported by three daily conversations. A review date of 28 February was set.
71. On 25 February, Mr Poon's brother visited him. He noticed Mr Poon had marks on his neck. Mr Poon said they were due to him not being able to shower properly. At around the same time, a prisoner on the same wing as Mr Poon told the investigator that others had noticed Mr Poon had red marks on his neck. Mr Poon

told them the marks were from a new prison-issue electric razor. There is no evidence staff observed or documented any concerns.

72. At around 10.40am on 26 February, an officer met Mr Poon for a keyword session. Mr Poon told the officer that he was doing well but was slightly bored with the regime as he was in his cell for 22 to 23 hours each day. He said he spent his time reading and made full use of any time out of his cell to talk to others. He said he felt safe on the wing and had no major issues.
73. At around 1.45pm on 28 February, healthcare staff recorded in Mr Poon's medical records that they had received the discharge summary from the psychiatrist at Chase Farm Hospital.
74. At around 2.10pm that afternoon, a senior officer chaired Mr Poon's ACCT review as the other senior officer was not working. Mr Poon and the chaplain attended. Mr Poon said his brother's telephone number had been added to his prison phone account and he was trying to get used to the regime. He told the review that he was staying positive about the charges against him and was hopeful that he would be granted bail. The chaplain asked Mr Poon how he felt about his next court hearing on 19 March. Mr Poon said that if bail was not granted, he would carry on with his legal fight. He denied thoughts of suicide or self-harm. The senior officer and the chaplain agreed the ACCT would be closed with a post-closure review date set for 7 March. The senior officer documented the review in Mr Poon's electronic prison record. He told the investigator that he did not know why there was no review documentation in Mr Poon's ACCT.
75. A prisoner who lived in the cell next to Mr Poon's told the investigator that at the end of February 2025, he noticed Mr Poon was not himself as he was not talkative. Mr Poon told him he was okay but felt lonely. The prisoner said that from that point, he noticed Mr Poon becoming more withdrawn. He thought Mr Poon may have had contact with his solicitor at around that time (Mr Poon's phone records show that he phoned his solicitor on 3 March).
76. During the first three days of March, wing officers made entries in Mr Poon's seven-day ACCT post-closure monitoring form. They wrote that Mr Poon had been spending time reading in his cell and mixing with his peers on the wing. He said he was a little bored but felt fine. Staff noted that he was calm. The following four days were left blank.
77. At around 11.34am on 4 March, two doctors and the Early Days in Custody Mental Health Lead, discussed Mr Poon at the mental health team meeting. They reviewed the discharge summary from the psychiatrist, noting that Mr Poon's risk of self-harm persisted but his presentation was in keeping with his current situation. The review concluded that Mr Poon would be discharged from the mental health in-reach team and his risks of self-harm were to be managed through ACCT monitoring.
78. At around 5.00pm on 8 March, a senior officer completed an ACCT post-closure review. The senior officer told the investigator that he spoke to an officer to inform the review and they both then spoke to Mr Poon for around ten minutes at his cell door. The senior officer said he was covering two wings (due to a lack of supervising officers) at the time and he spoke to Mr Poon at the end of the daily

regime. The senior officer told the investigator that he saw Mr Poon on his bed watching television and he seemed fine. Mr Poon told him he was in contact with his brother and was pursuing an appeal. The senior officer said there were no indications during their interaction that Mr Poon felt suicidal. He recalled that most of the sections in the daily monitoring form were completed (in fact half were missing). He said that sometimes these were missing. He did not remember over half being missing for Mr Poon.

79. At around 10.21am on 11 March, Mr Poon spoke to his solicitor by telephone (legal calls are confidential and not monitored). He spoke to his brother by telephone later that evening. The investigator listened to the recording of the call between Mr Poon and his brother. Mr Poon referenced the call with his solicitor but did not go into detail. The investigator noted that the call appeared normal and Mr Poon gave no indications that he was in crisis.
80. A prisoner told the investigator that on 12 March he spoke to Mr Poon at around 4.30pm/5.00pm. Mr Poon told him he was okay. The prisoner said he would bang on Mr Poon's wall every evening and he would bang back. He did so as usual during the early evening, but Mr Poon did not respond.
81. Closed circuit television (CCTV) footage showed Mr Poon collecting his evening meal and returning to his cell at around 4.37pm. At 4.48pm, Mr Poon was checked again as officers conducted a roll check (a routine check to ensure prisoners are in their correct cells).
82. At 9.02pm, while conducting wing welfare checks, an officer checked on Mr Poon through his cell door observation panel. She had no concerns. Mr Poon did not activate his emergency cell bell during the night and staff had no reason to check him.

Events of 13 March 2025

83. The investigator watched CCTV and body-worn video camera (BWVC) footage, listened to staff radio communications and obtained prison statements and London Ambulance Service records. The following account is taken from all sources.
84. At around 5.28am, during a routine roll check, an officer looked through Mr Poon's cell door observation panel and turned on his night light. In her statement, she stated she saw what she first thought was Mr Poon sitting on the bottom bunk by the window. She then noticed his head was drooped and he was hanging with a ligature around his neck. She immediately radioed a code blue medical emergency (indicating a prisoner is unconscious or having trouble breathing) and activated her BWVC.
85. The officer tried to break her sealed pouch (which contains a cell key to be used in an emergency at night). She shouted to an Operational Support Grade (OSG) for help. At 5.29am, a senior officer arrived and opened the cell door.
86. The senior officer held Mr Poon's weight and the officer removed the ligature. They moved Mr Poon to the floor and the officer began cardiopulmonary resuscitation (CPR) before another senior officer took over. Two officers arrived within a minute and took turns in delivering CPR.

87. At the same time, another officer, who was on G Wing and heard the emergency code blue on her radio, went to D Wing. She went into Mr Poon's cell and checked for a pulse. She was unable to find one.
88. At 5.31am, two nurses arrived with emergency bags. One of the nurses took over CPR. The nurse told the investigator she noticed Mr Poon's body was stiff and he looked blue. She was unable to insert an airway as his jaw was stiff. She thought he was already dead.
89. At 5.38am, an ambulance arrived with two paramedics. The paramedics went into Mr Poon's cell at 5.41am and assessed him. At 5.48am, they declared life extinct.

Contact with Mr Poon's family

90. At 6.40am on 13 March 2025, the prison appointed a senior officer as family liaison officer. At 8.35am, the senior officer and an officer visited Mr Poon's next of kin. They broke the news of his death and offered support. The prison contributed toward the cost of Mr Poon's funeral in line with national policy.

Support for prisoners and staff

91. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners with support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted 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 and support the prisoners most affected by a death.
92. After Mr Poon's death, the Head of Safety 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.
93. Both nurses who attended the emergency response did not take part in the hot debrief. The Head of Safety told the investigator that they had already left when he arrived (he was beginning his shift that morning and both nurses had finished a night shift). Both nurses said that Practice Plus Group offered them support.
94. The prison posted notices informing other prisoners of Mr Poon'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 Poon's death.

Post-mortem report

95. The pathologist gave Mr Poon's cause of death as suspension by ligature.

Inquest

96. At an inquest held between 16 and 26 March 2026, the Coroner concluded that Mr Poon died by suicide.

97. The Coroner concluded that the ACCT process was not managed and implemented properly. The frequency of ACCT checks were inappropriately reduced and ACCT monitoring stopped too soon. There was insufficient accountability by staff, evidenced by inconsistent ACCT reviews that lacked structure, inadequate record keeping, lack of follow-up on agreed actions, lack of handover between staff and an important email that was not read or followed up on. There were gaps in staff training and knowledge, and they overly relied on Mr Poon's presentation. These failures contributed to Mr Poon's death because they led to an inadequate assessment of his risk of suicide.
98. The Coroner found that despite a nurse having formed the correct view that Mr Poon was dead and that continuing CPR was futile, she took over from prison staff and continued until paramedics arrived. This was unprofessional, inappropriate and did not afford Mr Poon dignity or privacy.
99. The Coroner issued a Prevention of Future Deaths report (also known as a Regulation 28 report), which can be issued following an inquest to highlight concerns and request action to prevent similar deaths in the future. The report was directed to the Governor of HMP Pentonville and the Chief Executive of Practice Plus Group, identifying actions required to prevent similar future deaths.

Findings

Assessment of risk

100. HMPPS' Prison Safety Policy Framework sets out the mandatory requirements for staff on identifying the risks of suicide and self-harm and supporting those at risk to reduce harm. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service case management approach used to support prisoners identified as at risk of suicide or self-harm.
101. PSI 07/2015 on Early Days in Custody requires that any prisoners arriving with a suicide and self-harm warning form or any other indication that they may be at risk of suicide or self-harm are managed in line with safer custody guidance. The policy requires staff to be alert to the enhanced risk posed by prisoners in particular circumstances, for example, those in prison for the first time and those with a history of suicide attempts.
102. Mr Poon arrived at Pentonville with a number of significant risk factors: it was his first time in prison; he was a former police officer under arrest for serious offences and had recently been dismissed from the police service and he had been detained in a mental health hospital less than a month earlier after a suicide attempt. Court staff appropriately completed a suicide and self-harm warning form and updated Mr Poon's escort record to reflect these risk factors.
103. An officer and nurse interviewed Mr Poon when he arrived in reception. The officer could not recall if he had seen Mr Poon's suicide and self-harm warning form but was aware of some suicide risk. Mr Poon denied thoughts of suicide during both interviews. Despite his calm presentation and denial of thoughts of suicide, the nurse identified that Mr Poon's risk factors indicated his risk of suicide was high, and began ACCT procedures. The nurse was right to begin ACCT procedures, however we are concerned that the officer who had already processed Mr Poon's arrival at Pentonville chose not to initiate ACCT and relied too heavily on Mr Poon's demeanour without fully considering his objective risk. We are also concerned that, despite Mr Poon having significant risk factors to indicate his suicide risk was high, staff considered that checks of once an hour were sufficient to support him during his early days in prison. We consider that to be a low level of support to someone with a high suicide risk.
104. Once the ACCT was opened, a senior officer promptly initiated an immediate action plan, and a timely assessment and case review was conducted the next day, with representatives from the early days in custody team and the chaplaincy. While an assessment took place as required before the review, the chaplain told us that he did not have all the information he needed and he waited for the review to complete the assessment. This meant that the review was not as informed as it might have been. We found that the review lacked sufficient exploration of Mr Poon's protective factors such as family support, and did not assess how these might have mitigated his suicide risk, especially since they were present during his recent suicide attempt. Additionally, a blank personal contribution plan (where prisoners can document triggers and what support helps them to cope) indicated a missed opportunity to engage Mr Poon more meaningfully.

105. At the same review, the frequency of checks on Mr Poon was reduced from hourly to once every three hours. We found that this decision was based too heavily on his presentation (a theme throughout the assessment of risk process), and despite limited information about his medical history, him having been at the prison for mere hours, and him being totally unfamiliar to staff. We consider that the frequency of checks was reduced prematurely, and his care plan was insufficient to manage the risk posed.
106. Subsequent ACCT reviews on 21 and 28 February were not multidisciplinary and continued to rely on Mr Poon's presentation, with insufficient consideration of his risk factors. We consider that the ACCT was closed prematurely. Due to staffing pressures, the post-closure review took place in a rushed way at Mr Poon's cell door, and overall, we found the post-closure process was managed poorly.
107. Pentonville was unable to provide the ACCT ongoing daily record (where officers record times of checks and information about a prisoner's welfare) for 14, 15 and 18 February 2025. For the remaining four days, records showed hourly checks, despite the care plan stating checks should occur every three hours. There was no documentation referencing the email sent on 17 February from the safer custody team to the three senior officers. All told the investigator that they either could not remember seeing it or had not taken any action. We are unable to establish whether checks continued to be undertaken hourly and if so, why this was. However, we found no evidence that this related to the email of 17 February.
108. Overall, we found that the management of Mr Poon's ACCT was poor. Case management was inconsistent, and most reviews were not multidisciplinary. While it was obvious the safer custody practitioner's role was valued as a link with the healthcare team and we acknowledge his extensive experience in managing ACCTs, the presence of a clinician would have offered a clinical perspective of Mr Poon's risk of suicide, particularly given his recent discharge from a psychiatric hospital. Similarly, while the chaplain is respected in his chaplaincy role, staff relied on him too much to make the reviews multidisciplinary.
109. We conclude that staff relied too heavily on what Mr Poon was telling them. He was an intelligent, articulate man, who presented as calm. Some staff described talking to him as like talking to a colleague. We consider that Mr Poon's presentation gave staff a false sense of security and they did not keep in mind his considerable risk factors, that had not changed in the time he spent at Pentonville.
110. The Head of Safety told the investigator that quality assurance checks of ACCTs generally showed no concern, aside from some missing signatures. HMP's Early Learning Review recommended that Pentonville should consider a fact-finding exercise regarding the missing documentation and requested an update by 4 April 2025. We are disappointed that this was not prioritised by the prison and was completed on 4 August, nearly five months after Mr Poon's death. The fact-finding exercise recommended remedial actions to support the ACCT case manager and temporary oversight of ACCTs they manage for three months. The fact-finding exercise did not establish what had happened with the missing documentation.
111. We are concerned both by the number of failings identified in the prison's management of Mr Poon's risk of suicide and self-harm risk and the slow response to the Early Learning Review. Our investigation found failings far beyond one

officer and the action plan following the fact-finding exercise does not adequately address these problems.

112. We therefore make the following recommendations:

The Governor should ensure that there is a robust and effective quality assurance process in place to monitor the quality of ACCT management, focusing particularly on staff:

- **identifying prisoners' objective risk factors and basing assessment of risk on them;**
- **setting meaningful and tailored care plan actions; and**
- **completing and properly securing all ACCT documentation.**

Induction

113. PSI 07/2015 on Early Days in Custody (EDiC) requires Governors to ensure that all prisoners are given the guidance and information they need about the issues that are important to them. Prisoners should receive an induction which consists of two parts, an introduction to custody and a localised introduction specific to each prison. The first induction should take place within the first five days (reception counting as day one), with guidance reflecting that best practice is that both take place on day two. The policy requires prisons to make arrangements for those whose induction is delayed so that they can obtain information in the interim.
114. At Pentonville, for prisoners who move straight from reception to the Vulnerable Prisoners' Wing, induction takes place once a week. When Mr Poon arrived, induction sessions were run every Wednesday. Mr Poon arrived on a Thursday evening, and was appropriately identified as suitable for the Vulnerable Prisoner's Wing, but that meant he would wait five full days before his induction. A senior officer told the investigator that he introduced Mr Poon to a Listener who had previously worked as an Insider to support Mr Poon in the meantime. On 21 February 2025, the senior officer emailed the activities hub to ask for Mr Poon to be added to the list for a basic skills assessment. There is no evidence the assessment or induction ever took place.
115. One of Mr Poon's risk factors was that it was his first time in prison. Although the prison made arrangements to support Mr Poon in the interim, this period was likely to have been confusing and upsetting for him. Mr Poon never had a basic skills assessment which prevented him from engaging in activities that may have distracted and supported him. It is impossible to say whether a timely induction and basic skills assessment to enable him to access education and/or work would have changed the outcome for Mr Poon. However, it is vital that all prisoners, including those identified as vulnerable, have equal access to a full induction in line with policy on the early days in custody. While Pentonville tell us they have begun to make changes to ensure all prisoners receive a timely induction, this has not yet been fully implemented. We therefore make the following recommendation:

The Governor should ensure that prisoners located on the Vulnerable Prisoners' Wing receive a full induction, including a basic skills assessment, within the first five days in custody, in line with PSI 07/2015.

Clinical review

116. The clinical reviewer concluded that the healthcare Mr Poon received at Pentonville was generally equivalent to that which he could have expected to receive in the community.
117. The clinical reviewer found that the decision not to add Mr Poon to the mental health caseload was appropriate as he did not require the service. However, they were concerned about the quality of risk management, communication and effective working in relation to the ACCT. The clinical reviewer made a number of recommendations related to ACCT processes, which the Head of Healthcare will need to address and which we have covered in the section related to assessing Mr Poon's risk.

**Prisons &
Probation**

Ombudsman
Independent Investigations

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

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

T | 020 7633 4100