Investigation into the death of a man at HMP Pentonville in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of the investigation into the apparently self inflicted death of a man while in the custody of HMP Pentonville. The man was found during a routine check with a ligature around his neck. I extend my condolences to his family and friends.

The investigation into the man's death was undertaken by one of my senior investigators. In addition, a clinical review was conducted by a doctor on behalf of NHS Islington. I am most grateful for her contribution. I would also like to take this opportunity to thank the Governor of Pentonville and his staff for their cooperation with the investigation. I am sorry that this report has been slightly delayed.

The man was released from prison following a two year sentence on 6 May 2011. Two days later he was arrested and charged with serious sexual and violent offences. He was remanded into custody at Pentonville on 10 May. His death came on his fifth night in the prison in his cell in the segregation unit.

There can be little doubt that the man understood the seriousness of his situation. He almost certainly realised that, if found guilty, he would have received a lengthy sentence. He was also being treated as a prisoner potentially requiring the highest security categorisation. The man had a history of depression (and was receiving medication for this) as well as drug and alcohol misuse. Taking these factors into account, one must consider that he was vulnerable. However, during his short time in prison, the man chose to portray himself as confident and untroubled. He sought no support from staff and revealed nothing of his innermost thoughts.

The report makes two recommendations as a result of the investigation, one concerning healthcare record keeping and the other regarding the checking of prisoners in the segregation unit. In this final version of the report, I am able to reflect that the National Offender Management Service (NOMS) has accepted both recommendations. However, I do not think that either would have changed the tragic outcome.

I am very grateful to the man's mother who considered the report at the draft stage. Although she had a number of questions about the care and treatment her son received at Pentonville, she preferred to raise them at the inquest.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2012**

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SUMMARY

1. The man was arrested and charged with serious sexual and violent offences just two days after being released from HMP The Mount. On 10 May, he appeared at the local magistrates' court and was remanded into the custody of HMP Pentonville.

2. The man had a history of depression, which he disclosed to the reception nurse, and for which he was being prescribed citalopram (an antidepressant medication). He said that he did not have any thoughts of self harm or suicide. He told the nurse that he had been using drugs and alcohol prior to coming into custody.

3. The man was later assessed by a prison doctor, who prescribed the antidepressant medication and placed him on an alcohol detoxification programme. (During the detoxification programme, the patient is prescribed a decreasing dose of medication to help relieve the dangerous symptoms of alcohol withdrawal.) The man was then reviewed by a substance misuse specialist nurse. The nurse saw no visible signs of alcohol withdrawal.

4. The following day the man was assessed by the substance misuse specialist doctor. The doctor noted that he was low in mood, had low energy levels and a poor appetite. He was reminded to take his medications regularly, as he had missed a dose. The doctor assessed the man's mental health and recorded that he did not report feeling suicidal.

5. On 13 May, a Friday, the man was informed that he was being assessed as a potential category A prisoner (the highest category prisoner who must be held in the most secure conditions). A final decision would not be made until after the weekend. In the meantime, he was moved to the segregation unit (the most secure part of the prison and where prisoners who cannot be managed on the normal wings are held).

6. During the day of Saturday 14 May, the man asked if he could have a radio. Because he had been well behaved and was not thought to pose a risk to himself or to others, staff agreed. He was given a standard issue radio with a detachable electric flex.

7. That evening, the man was checked about once an hour by the officer carrying out the night duty. The officer checked the man at 11.00pm and then again at about 12.30am. At that check, he realised that the man had a ligature (the radio flex) around his neck, tied to the tap fittings on the cell sink.

8. The officer used his radio to alert the prison to a medical emergency and the senior officer on duty arrived at the scene within seconds. The two officers went into the cell, removed the ligature and began attempting to resuscitate the man. Nursing staff arrived shortly after and continued the attempts. Paramedics were on the scene within about ten minutes of the man being found. Sadly, despite the best efforts of those involved, he could not be resuscitated and was pronounced dead at 1.15am.

9. We make two recommendations as a result of this investigation. One relates to the completion of healthcare records and the other the checking of prisoners in the segregation unit. However, we do not think that either would have altered the outcome. In his short time at Pentonville, the man apparently showed no signs that he was struggling to cope.

THE INVESTIGATION PROCESS

10. Our office was informed of the man's death and the investigation was allocated to one of my investigators. My investigator visited Pentonville on 18 May. During the opening visit, she met relevant staff and visited the segregation unit and the cell in which the man died. She was provided with copies of the prison and health records and other documentation relating to his time in custody. Notices were issued to staff and prisoners at Pentonville informing them of the investigation and inviting them to contact the investigator should they wish to talk to her about the investigation. No-one came forward in response to the notices.

11. A review of the clinical care the man received at Pentonville was undertaken on behalf of NHS Islington.

12. My investigator requested copies of the man's prison and medical record from HMP The Mount from where he had been released on 6 May 2011. The medical record was shared with the clinical reviewer. My investigator also spoke to the man's criminal defence solicitor by telephone.

13. The investigator carried out interviews with discipline staff in July. She and the clinical reviewer went to Pentonville again in August to conduct joint interviews with healthcare staff. One member of healthcare staff who had contact with the man while he was at Pentonville had since left the prison. She contributed to the investigation by email. Both her response and the transcripts of interviews conducted as part of the investigation are attached as annexes. The Governor was provided with written feedback following the interviews. The issuing of the report has been slightly delayed due to workload pressures.

14. HM Coroner for Inner North London was contacted and informed of the nature and scope of the investigation. On completion a copy of the report will be sent to him to assist his enquiries into the man's death.

15. One of the Ombudsman's family liaison officers contacted the man's mother shortly after his death. She explained the investigation process and gave her the opportunity to raise any concerns or questions she wished to be addressed as part the investigation. The man's mother said that she would like to know why he had been allowed a radio with a flex in his cell.

HMP PENTONVILLE

16. Pentonville was built over 150 years ago, and, as a local prison, serves the courts of North London. It is a category B prison and can accommodate up to 1,310 adult male prisoners, either convicted or on remand.

17. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. Category A prisoners would be highly dangerous to the public, police or national security if they were to escape. They must be held in the tightest security conditions. A small number of prisons in England and Wales are suitable for holding category A prisoners. These prisons form the high security estate. Category B prisoners are those for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C prisoners cannot be trusted in open conditions but are unlikely to make a determined escape attempt. Category D prisons operate open conditions and hold prisoners who can be trusted not to try and escape.

Healthcare

18. A manager heads Pentonville's healthcare department, with three organisations providing health services. Whittington Health is the lead contractor and provides primary care services. Camden and Islington Foundation Trust provides substance misuse and mental health services and Barnet, Enfield and Haringey Mental Health Trust provides psychiatric care.

19. The healthcare centre is a relatively new purpose-built building offering both inpatient beds and a day care facility for prisoners with mental health problems. There are primary care facilities on the wings, including a consulting and dispensary area. Healthcare staff are on duty 24 hours a day. Doctors, mental health and nurse-led clinics are available, as well as a range of more specialised services.

Drug and alcohol treatment

20. Pentonville has an Integrated Drug Treatment Service (IDTS) on E and F wings. IDTS is a Prison Service scheme which aims to increase the amount and quality of substance misuse treatment available to prisoners, with particular emphasis on the early days in custody. It is intended to improve the integration between clinical and non-clinical services and reinforce continuity of care from the community into prison, between prisons, and on release into the community. At Pentonville, prisoners identified as having drug or alcohol problems are generally initially located on F wing to begin treatment. As their individual treatment stabilises they may move to E wing to continue treatment.

Her Majesty's Chief Inspector of Prisons (HMCIP)

21. HM Chief Inspector of Prisons led the most recent inspection of Pentonville in February – March 2011. In the foreword the Chief Inspector, noted that the prison holds an ever changing population drawn from some of London's poorest

boroughs. In addition, its prisoners have some of the highest levels of mental illhealth and substance misuse of any local prison in the country. Despite these challenges, Pentonville was found to be making progress.

22. In terms of safer custody and suicide prevention, the inspectorate noted that there was some "reasonable support" for those prisoners at risk of self harm, but that formal procedures were underdeveloped.

Segregation Unit

23. Segregation units are small, separate units within the prison for prisoners who cannot be managed on the main wings for some reason. Segregated prisoners are held in single cells and have a restricted regime. At Pentonville, the segregation unit has 12 single cells. HMCIP found the unit to be "basic but decent" with generally "professional and helpful" staff.

Independent Monitoring Board (IMB)

24. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are unpaid volunteers and are independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and areas of concern.

25. The latest IMB report covered the period from 1 April 2009 to 31 March 2010. The executive summary noted that progress had been made in several areas. The Board praised the "dedication and professionalism of managers and staff". However, they noted that "[e]ven with their best efforts, the prison's mixed and transitory population, old and overcrowded buildings and inadequate facilities hamper the delivery of a safe, decent and purposeful environment for prisoners."

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT, the Prison Service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.

Previous deaths at Pentonville

27. Since the Ombudsman started investigating deaths in custody in April 2004, there have been 15 apparently self inflicted deaths at Pentonville, including that of the man. There are no particular similarities between the recommendations made in previous reports and those made in relation to his death.

KEY EVENTS

28. The man was born in April 1982. He had a history of offending and this was not his first time in custody. He had a history of depression, which he disclosed during previous custodial sentences. In 2008, while serving a nine month sentence, he told staff that if they took away his television they would "find him hanging". He also said that he sometimes thought about killing himself, but did not want to do it. This resulted in him being monitored on an ACCT plan for a week.

29. In 2009, the man received a two year prison sentence, some of which he spent at Pentonville. During that sentence, he reported that he had a history of excessive alcohol use. In 2011, as he approached the end of the sentence, he complained of depression and was prescribed antidepressant medication (citalopram). On 23 March, during an appointment with the nurse practitioner at HMP The Mount, the man said that he felt anxious and depressed about being released in May and had nowhere to live. He said that he "sometimes thinks he would be better off dead, but could not kill himself" and had no suicidal plans. On 4 May, he repeated that he felt anxious but not suicidal.

30. On 6 May, the man was released from HMP The Mount, having completed his sentence. Two days later, he was arrested by the police and charged with rape and violent offences. He was held in police custody until he appeared in court.

31. While in police custody on 8 May, the man told staff that he suffered from depression and was taking 20 milligrams (mg) of citalopram daily. It was noted in his custody record that he was deaf in his right ear, did not have a history of self harm and was not dependant on alcohol or drugs. He was to be monitored every hour. A police doctor assessed him on 9 May and concluded that he posed a "standard" risk to himself. The doctor deemed him fit for detention and interview and prescribed a dose of citalopram to be taken that evening.

32. On 10 May, the man appeared at Highbury Corner Magistrates' Court. While at court, his criminal defence solicitor visited him in the cells. The investigator spoke to her by telephone. The man's criminal defence solicitor said that she had not met the man before that day. She said that he had seemed quiet, but did not give her any reason to worry that he might harm himself. She described him as "likeable" and realistic about the seriousness of the situation he was in. She said that he knew he would not be granted bail. She told him that they would talk more when she visited him in prison. Following his court hearing, he was remanded into the custody of HMP Pentonville until 26 July, when he was to attend court again.

33. On arrival at Pentonville, the man underwent a first reception health screen (a general overview of a prisoners health needs) with Nurse A. He disclosed his history of depression and told the nurse that he was taking citalopram. He also said that he took cocaine and cannabis and drank excessive amounts of alcohol on a daily basis. The nurse recorded in his medical record that he did not have any current thoughts of self harm and referred him for alcohol detoxification. (When people who are used to regularly drinking alcohol stop drinking suddenly,

they may experience withdrawal symptoms. These can include shaking, sweating, nausea and even seizures. Alcohol withdrawal can be very dangerous and needs careful monitoring. If necessary, the individual can be placed on a detoxification programme during which they are prescribed a decreasing dose of medication to help relieve withdrawal symptoms.)

34. Nurse A was interviewed as part of the investigation. She said that, on meeting the man in the reception area, she was immediately struck by how confident he seemed. As they walked across to the private room where she carried out the assessment, she noted that he held his head high and did not seem worried. The nurse told the investigator that she did not ask him about the offences he had been charged with. During the assessment, according to the nurse, he was "upbeat" and made a joke.

35. The man told Nurse A that he had recently been drinking "a lot" of alcohol, although the nurse could not recall in interview whether he described drinking "binges" or more constant drinking. She asked him if he was experiencing any symptoms as a result and he said that he was. However, the nurse said that he told her he had only been released from prison two days before his arrest, and so she knew that he had only been drinking alcohol again for two days. She said that she saw no signs of heavy alcohol use or symptoms of alcohol withdrawal. (The nurse did not record that the man had only been out of prison for two days in his medical record.)

36. As part of the assessment, Nurse A asked the man a series of direct questions about his current mental state, including whether he had any thoughts of harming himself. She said that the man "obviously wasn't very happy" to be in prison, but he said that he had never harmed himself before and had no such thoughts now. She had no concerns about his risk to himself following the assessment. The nurse referred him to the doctor because of his alcohol use and his prescription for antidepressant medication.

37. At about 7.30pm, Dr A, the prison's lead doctor, assessed the man following his healthscreen. She was also interviewed during the investigation. The doctor said that she knew that the man had been given vulnerable prisoner status because he had been charged with a sexual offence. (Vulnerable prisoner status is given to those prisoners who cannot live on the normal prison wings for some reason. They are housed in separate areas of the prison and are kept separate from prisoners on normal location. Often, prisoners charged with or convicted of sexual offences are given vulnerable prisoner status because they may face bullying by other prisoners. Prisoners who are less well able to cope with life in prison may also be vulnerable prisoners.)

38. During Dr A's examination of the man, he told her that he suffered with depression and was prescribed citalopram. She prescribed one month's supply, as well as medication for asthma, which he also said he had. (The doctor allowed him to keep the asthma medication in his cell. She directed that he collect the antidepressant medication from the nurse on the wing each day.) He told the doctor that he drank a great deal of alcohol, saying that he consumed around 16 cans of strong lager or cider, mixed with vodka and wine, every day. On that

basis, the doctor placed him on an alcohol detoxification programme. (The alcohol detoxification programme at Pentonville consists of daily doses of chlordiazepoxide, vitamin B injections and tablets and thiamine tablets. The dose of chlordiazepoxide reduces slowly over a set number of days. Again, this medication must be collected on a dose by dose basis from the nurse on the wing.)

39. In interview, Dr A said that the man did not tell her, and she did not know, that he had only been out of prison for two days before he was arrested. She said that, had she known, she would have tried to assess how much alcohol he had consumed while at liberty, but that he might still have been suitable for the detoxification programme. The doctor said that the man "did not look like he was withdrawing acutely" during her assessment. She referred him to the substance misuse specialist team for further assessment and monitoring.

40. The doctor explained that only prisoners who are suffering with severe depression (or other serious mental health problems) or who express suicidal thoughts are referred to the mental health inreach team. Prisoners with lower levels of depression are managed by the prison doctors. The doctor said that she specifically asked him about thoughts of self harm or suicide and he denied both. She told the investigator that she had no concerns that he might harm himself, but that if she had, she would have opened an ACCT plan.

41. About twenty minutes later, at just before 8.00pm, the man was assessed by Nurse B, from the substance misuse team. Nurse B was also interviewed as part of the investigation. He said that the man came across as a "pleasant" man who was "candid" about his alcohol use. The man told the nurse that he had been released from prison a month previously and had been drinking heavily since his release. The nurse said that the man "made it sound like he was continuously drunk basically for a month". (The nurse was not aware that the man had only been released four days earlier until he was interviewed as part of the investigation.) He recorded details of his assessment in the man's medical record, noting that he started abusing drugs aged 13 and began drinking at the age of 20. The man told him that he had been sleeping a lot over the previous two days and had suffered from seizures, sweats, shakes and nausea during previous episodes of alcohol withdrawal. However, the nurse saw no signs of alcohol withdrawal symptoms at the time of the assessment.

42. Nurse B explained that Pentonville offers no specific clinical treatment for prisoners who are heavy users of cocaine or cannabis. He said that prisoners with high use of these substances may experience agitation, frustration and insomnia during withdrawal. The nurse said that chlordiazepoxide (which has sedative effects) is helpful in combating these symptoms. The man was prescribed this as part of his alcohol detoxification. He was given his evening doses of chlordiazepoxide, vitamin B and thiamine.

43. Nurse B explained that his assessment did not focus on mental health issues but that he saw no signs that the man was vulnerable or a risk to himself. He said that normally prisoners undergoing alcohol detoxification programmes are housed on F wing, where nursing staff can monitor them and deliver their medication.

However, because the man was a vulnerable prisoner, he was to be located on G1 landing, the vulnerable prisoner (VP) unit.

44. Officer A was working in the first night centre (where most prisoners will spend their first night in prison) on 10 May and was interviewed as part of the investigation. He explained that he recognised the man because he had been at Pentonville before. The officer remembered that the man had not been a vulnerable prisoner during his last stay at the prison and asked him about this. The man told him that it was the result of the charges he was facing but that they were "just allegations". The officer said that, although it was clear the man was not happy to be in prison again, he did not seem dejected. They continued to chat and the officer told the man that he would try to help him get a job on the VP wing.

45. Officer A told the man that he would be sharing a cell with another vulnerable prisoner that night because it was the only available cell. In fact, the two men were given a cell on G2, which is the VP unit overspill. G2 is the landing directly above the G1, the VP unit. The overspill is used when there are no available cells on G1.

46. In interview, Officer A said that he saw no reason to worry about the man that evening. He showed no signs of being particularly concerned about being back in prison or about the charges he was facing. The officer said that if he had had any concerns about him he would have told the senior officer on duty and would have opened an ACCT plan.

47. Due to the seriousness of the offences the man had been charged with, it was possible that he would become a category A prisoner. Such decisions are made by a specialist team in the National Offender Management Service (NOMS) not by Pentonville staff. On his arrival at the prison, staff began collating the information required to make the decision and the relevant paperwork was faxed to the NOMS team on 10 May.

48. At about 11.30am the following day, 11 May, the substance misuse specialist doctor who was also a trainee psychiatrist assessed the man with Nurse B also present. The doctor noted in the man's medical record that he had seen a psychologist when he was 13 years old but had not had any involvement since and he did not have a history of self harm or psychosis. The man told the substance misuse specialist that he had been prescribed citalopram eight weeks earlier while serving a sentence at HMP The Mount. The doctor recorded that the man maintained good eye contact during the assessment, but said that he felt low, had poor concentration, was sleeping a lot and had low energy and a poor appetite. The substance misuse specialist noted that he displayed no signs of alcohol withdrawal however he was to continue on the ten day detoxification programme.

49. The substance misuse specialist no longer works at Pentonville and was not interviewed in person. However, she responded by email to a number of questions posed by the investigator and clinical reviewer. She wrote that, during her assessment of the man, she did not think he was "holding anything back",

although he did not want to discuss his background. The doctor said that she did not identify any signs of severe depression. She wrote that she was worried that, because he was in a cell on G2, he was spending a lot of time locked in his cell, which might add to his feelings of depression. (Because vulnerable prisoners must be kept separated from the rest of the prison population, the opportunities for them to be unlocked are more limited and must be carefully managed. Managing the unlock and movement of prisoners on the VP overspill is more difficult because the other prisoners on the wing are not vulnerable.)

50. In her email, she explained that during appointments with new patients she carries out a risk assessment, which is similar to that which is conducted if someone presents in similar circumstances at an accident and emergency department in hospital. The assessment is carried out by asking a series of direct questions covering, for example, previous suicide attempts or acts of self harm as well as the patient's current mental state. She wrote that she "did not think that he was withholding plans to suicide from me at the time of assessment. He was forthcoming with information about his mood … ". She added that she had tried to undertake a full psychiatric assessment during her appointment with the man, to establish if he suffered with a personality disorder. However, because he would not talk about his past, she was unable to.

51. The substance misuse specialist said that her main concern about the man was that he had already missed his morning dose of chlordiazepoxide. She explained that, in order to avoid some of the more dangerous symptoms of alcohol withdrawal, it is important that patients take the prescribed doses. Healthcare staff interviewed explained that chlordiazepoxide, like all other medications, is administered to prisoners at the treatment hatch on each wing. Prisoners prescribed medication are unlocked at medication dispensing times and must attend the hatch to receive their dose from a nurse. It is the prisoner's responsibility to collect their medication.

52. She wrote in her email that she and Nurse B highlighted to G wing staff that the man had failed to collect his medication that morning. She also reminded the man of the importance of taking his chlordiazepoxide. In fact, the man did not take any of his prescribed medication on 11 May. (On 12 May, the man did not take his medication in the morning but did in the afternoon and evening. The following day, he again missed his morning medication but received later doses.)

53. Nurse C was interviewed as part of the investigation. She remembered giving the man his medication on his first night in prison. She thought that he had missed other doses when living on G2 landing because the staff responsible for unlocking vulnerable prisoners on the overspill were not aware that the man also needed to collect medication. Healthcare staff said, however, that prisoners are also encouraged to tell staff that they need to be unlocked for medication. They also said that, if a prisoner thought he had not been unlocked and should have been, he could tell wing staff and would be able to collect the medication at another time. Nurse C explained that the system for identifying prisoners requiring medication had changed since the man's death and was now much easier. The nurse thought that it would be unlikely that a prisoner would not be unlocked for medication under the new system.

54. On 13 May, the man was told that he was to be considered a potential category A prisoner over the weekend and that, until a final decision had been made early the following week, he would be held in the segregation unit. The prison's security governor explained that the NOMS team responsible for making the categorisation decision had asked for more time to consider the man's categorisation. In the meantime, they had directed that he should be classed as a potential category A prisoner. According to the prison's local security strategy, any potential category A prisoner must be held in the segregation unit while the decision is made. If the NOMS team decided that the man was a category A prisoner, he would move to the nearest high security prison early the following week.

55. The prison's security governor explained that, while a potential category A prisoner, the man was allowed limited access to the telephones. Any visits he received would take place under strictly monitored conditions. (In fact, the man did not receive any visitors or make any telephone calls while at Pentonville.) While out of his cell, the man had to wear special yellow and green coloured clothing (known as "patches"). The brightly coloured outfit is designed to make the prisoner noticeable and is thought to make it easier for staff to monitor their whereabouts. Patches are also worn by prisoners who are considered to be an escape risk. When locked in his cell, the man was allowed to wear his own clothes.

56. One of the security managers on duty explained the decision to the man and he was also given written confirmation. It was noted in his electronic prison file that he had accepted the information and had been fully compliant.

57. Senior Officer (SO) A, the segregation SO, was interviewed as part of the investigation. He was on duty on Friday 13 May and met the man when he was brought down to the unit that afternoon. He said that he and his staff (most of whom were also going to be on duty over the weekend) explained the regime to the man, including access to Listeners and the Samaritans. (Listeners are prisoners trained and supported by the Samaritans to provide a confidential listening service to other prisoners. A prisoner can ask to speak to a Listener at any time, day or night. At Pentonville, prisoners can only access the Samaritans' telephone line during periods of unlock, using the standard prison telephones.)

58. The man seemed to be "perfectly alright" and compliant. That afternoon, he was able to borrow some books from the unit library and had about 20 minutes exercise in the segregation exercise yard. SO A explained that, generally, potential category A prisoners do not have a television or kettle in their cell and at night time most of their belongings are taken out of the cell. He said that this was to prevent them from using any items to help them escape or attack staff.

59. Staff interviewed told the investigator that where there are concerns that a prisoner might harm himself, other items can also be removed from the cell (such as that which could be used to make a ligature or to cut). Where the risk is considered to be high, the prisoner can be issued with special bedding which cannot be torn into strips. (It is quite common for prisoners who wish to harm

themselves to use their sheets to make a ligature.) The man was given standard issue bedding because he was not considered to pose a risk to himself. Although he had some items removed from his cell at the end of each day, this was for security reasons and not because he was considered vulnerable.

60. Nurse D, the deputy head of nursing, completed the segregation algorithm (checklist for assessment) for the man at 5.10pm on 13 May. The purpose of the algorithm is to ensure that the prisoner is mentally and physically well enough to be segregated. It is a requirement of Prison Service Order (PSO) 1700, Segregation. Nurse D was interviewed as part of the investigation. He explained that the algorithm consists of a number of set questions that are answered by looking at the available information, including the medical record, entries in the prison file, by speaking to officers and talking to the prisoner himself.

61. Nurse D described his meeting with the man. He said that he seemed "ordinary" and responded appropriately throughout. He was clean shaven and tidily presented (prisoners with mental health problems may not take care of their physical appearance). The nurse said that he took into account the fact that the man was prescribed antidepressants (but also said that this was very common across the prison population and not, in itself, a reason not to segregate). He also said that, although it was less common, it was also possible for a prisoner on an alcohol detoxification programme to be segregated. The nurse saw no reasons to worry about the man and got the impression that being in the segregation unit was like "water off a duck's back" for him. He concluded that the man could be segregated.

62. The nurse explained that segregated prisoners are given their medication at their cell door by the nurse. As a result, once segregated, the man did not miss any medication.

63. The nurse explained that, at the time, there was no computer terminal in the unit which allowed healthcare staff to make entries in the prisoners' medical records. He should have made an entry after completing the algorithm, but admitted that he had not done so. Nurse D said that, since the man's death, a computer terminal had been installed in the unit for healthcare staff to use. (A member of healthcare staff must visit the segregation unit every day to check the welfare of prisoners held there). At 2.27pm on Saturday 14 May, a nurse and doctor signed the segregation visitors' book to show that they had visited the prisoners in the unit. Neither made any entries in the man's record.

64. On the morning of Saturday 14 May, the man was allowed a shower. The SO described him as seeming "like any other segregation prisoner". He asked a few questions about how long it would take for the NOMS team to decide his categorisation and what would happen as a result. The SO reassured him that the decision would be made as soon as possible. In interview, SO A said that "he was just level, he was just an ordinary, level man that's a prisoner and that asked the right sort of questions for his future, there was nothing to say oh well I won't get there or I'm not going to contemplate that". The SO said that he saw no signs that the man was withdrawing from alcohol or drugs. The duty governor visited the unit during the morning and also recorded no concerns about the man.

65. During the afternoon, according to SO A, the man asked if he could have a radio in his cell to listen to a football match taking place that evening. The SO said that he had no concerns about agreeing the request because the man had been very compliant while segregated and appeared to pose no risk to staff or to himself. Segregation staff are trusted to make such decisions themselves, however, because of the man's potential category A status, the SO decided to discuss the request with the duty governor.

66. The duty governor was also interviewed during the investigation. She explained that the regime in the segregation unit is quite limited and prisoners tend to spend longer periods locked in their cells than on the normal wings. For that reason, staff do what they can to help prisoners there from becoming depressed, bored and isolated. As a result, prisoners who are not in the segregation unit for punishment are often given access to a radio. The duty governor said that SO A briefly discussed the man's request with her but she did not actually meet the man herself. On the basis of the information provided by SO A she agreed the request.

67. The governor was asked about the radios used at Pentonville. She said that they were standard radios, bought from Argos. The radios either need batteries or can be plugged into a wall socket, using a detachable flex. SO A described the flex as about two or three feet in length. Both the SO and the duty governor explained that, in the past, prisoners had been expected to purchase batteries for the radios, but they had complained about the cost. The investigator was also told that the large batteries required could be used as a weapon. As a result, staff decided that prisoners should also be given the electric flex, meaning that they could use the in-cell electricity. The duty governor said that, where there are any concerns about a prisoner's risk to self, the decision to give them a detachable flex would need to be carefully considered. However, as noted previously, staff in the segregation unit had no concerns about the man. First thing that afternoon, staff gave the man the radio.

68. During the afternoon, staff checked the man every half an hour and wrote an entry in his segregation book. SO A explained that this is standard practice for the first 24 hours that a prisoner is held in the segregation unit. After this time, the prisoner should be checked once an hour. The investigator was provided with the prison's local segregation policy, dated February 2011. The policy makes no mention of the regularity of checks that should be carried out on prisoners who are not on ACCT plans. The governor in charge of the segregation unit and safer custody issues, was asked whether there was any written guidance for staff about how regularly to check segregated prisoners. He confirmed that there is no such formal guidance but that it is "something that the staff do".

69. SO A said that when checked during the afternoon, the man "put his thumb up" and was usually sitting on his bed reading and listening to the radio. When the evening meal was served, he and the SO had a brief chat and the man thanked him for the radio. By all accounts, staff working in the segregation unit had no reason to worry about the man that day.

70. At 8.00pm on 14 May, Officer B began his shift on E wing. He was responsible for the normal wing and the segregation unit. He was interviewed as part of the investigation and said that, when he arrived on the unit, he counted the prisoners and received a handover from the evening staff. He also read the unit observation book (where information of note should be written). He said that no concerns about the man were raised either in the handover or in the observation book.

71. Officer B wrote in his statement that, on his arrival, he spoke to the man, who said he was okay. In interview, he said that he could hear that the man had a radio. When he checked him during the evening, the man was generally lying on his bed facing the door. The officer said that, during the evening, he changed the man's observation level to one check per hour, as he had been in segregation for more than 24 hours on 30 minute observations.

72. The investigator was provided with a copy of the segregation closed circuit television (CCTV) footage covering the period 11.00pm on 14 May to 1.15am on 15 May. According to the footage, Officer B checked a number of segregated prisoners, including the man, at 11.02pm. He returned to the unit again at 11.34pm and checked one prisoner (not the man). At 12.31am, he looked through the observation panel in the man's door. He saw the man sitting on his bed, apparently leaning against the metal sink unit at the end of the bed. At first, he said that everything appeared normal. As he walked away from the cell door, he explained that "something clicked and I thought it didn't look right". He looked through the observation panel again and realised that the man had something tied around his neck. He used his radio to alert the prison to a Level One emergency (a special radio code used for serious medical emergencies). While he waited for staff to arrive, Officer B began to get the cell key out of the sealed pouch he was carrying. (At night, staff on the wings carry a cell key in a sealed plastic packet. If they need to enter a cell in an emergency they must break the seal. If the seal is broken, the member of staff must complete paperwork to explain the reason for using the key. This process is a standard security requirement in prisons.)

73. Within less than one minute, SO B, the night orderly officer in charge of the prison, had arrived in the segregation unit. He used his keys to open the man's cell door and he and Officer B went into the cell. SO B was interviewed and said that, on going into the cell, he saw the man slumped by the sink unit, with the radio flex tied around his neck and to the tap fitting on the sink. The SO said that he took the weight of the man's body, to relieve pressure on the ligature, while Officer B used his anti-ligature knife to cut the flex. (All staff at Pentonville carry an anti-ligature knife, which is specially designed to safely cut ligatures from around a person's neck.) The two officers placed the man on the cell floor.

74. SO B realised that the man was not breathing and so he and Officer B began cardiopulmonary resuscitation (CPR). The SO delivered rescue breaths, while Officer B performed chest compressions. Officer B is trained in first aid and although the SO had not completed any first aid training for several years, he knew the correct ratio of rescue breaths to chest compressions.

75. A further six members of staff ran to the unit, all arriving within a minute of Officer B's initial radio call. The SO told one of the officers to ask the communications room to call for an ambulance. The SO then sent his assistant night orderly officer, Officer C and another member of staff to meet the ambulance at the gate.

76. There are three nurses on duty at night at Pentonville. Nurse E was in the A wing office when he heard the Level One emergency call. He was interviewed as part of the investigation and said that he immediately made his way to the segregation unit. Nurse C was the emergency response nurse that night and was in the C and D wing treatment room when she heard the radio call. She said that she grabbed the emergency medical equipment, including the oxygen cylinder. She met Nurse E on her way to E wing. The nurses explained that, at night, the gates which separate the wings are left open so that nursing staff are able to move around the prison, and particularly respond to emergencies, more easily.

77. According to the CCTV footage, Nurse E and Nurse C arrived at the man's cell at 12.33am. A third nurse, Nurse F arrived shortly after. The nursing staff took over CPR from SO B and Officer B. The CCTV footage shows one of the nurses leaving the scene, apparently to collect more equipment. It has not been possible to establish exactly what they needed to collect, but Nurse C thought it might have been the automated external defibrillator (AED – a machine which can help to restart the heart in certain circumstances by delivering an electric shock). Nurse C described the man as cold to the touch and his skin was blue (a sign that the patient is not getting any oxygen).

78. The first paramedic arrived at the prison at 12.40am and reached the man's cell at 12.44am. Two more paramedics were at the scene by 12.49am. They took over the resuscitation attempts. A fourth paramedic, in fact the local ambulance service duty manager, arrived at 1.01am. Despite the efforts of prison and nursing staff and the paramedics, the man could not be resuscitated and the paramedics pronounced that he had died at 1.15am.

Contact with the man's family

79. On his arrival at Pentonville, the man, although asked, chose not to provide the contact details of his next of kin or someone he would like contacted in an emergency. Following his death, the prison appointed a family liaison officer who contacted Islington Police on 15 May to ask them to search for any next of kin.

80. On the morning of Monday 16 May, the prison liaison officer contacted the police again to see if they had identified any next of kin. At 2.00pm, the police family liaison officer confirmed that he had visited the man's mother and had told her of the man's death. They passed his mother's contact details to the prison family liaison officer, who contacted her by telephone that afternoon.

81. The following day, the prison family liaison officer and the governor in charge of the segregation met the man's family at the Coroner's office. In line with PSO 2710, Follow up to a death in custody, the prison offered financial assistance with the cost of the man's funeral, which the prison family liaison officer attended.

Support for staff and prisoners

82. The duty governor on the day the man died, held a hot debrief for staff shortly after the man's death. Holding a hot debrief is a requirement of PSO 2710. The purpose of the meeting is to bring together staff who have responded to the incident, to give them an opportunity to talk about the events.

83. Most of the staff involved in the emergency response felt that they had received sufficient support from the prison management in the aftermath. The night orderly officer in charge of the prison that night gave all of the staff on duty that night the opportunity to finish their shift early and go home, although most chose to remain on duty for the remainder of the night.

84. The following night, the same members of staff had to deal with a serious fire on G wing. As a result, some had found it harder to deal with the events of that week and had required more intensive support.

85. The duty governor said that the other prisoners in the segregation unit realised that something serious was happening during the night. All of the prisoners at Pentonville were informed of the man's death by way of a notice from the Governor the following day. Those prisoners on ACCT plans were reviewed.

ISSUES

Clinical care

86. NHS Islington commissioned the clinical reviewer to consider the clinical care offered to the man at Pentonville. The clinical reviewer concludes that the man received a standard of healthcare better than that he might have received in the community.

87. The clinical reviewer notes that the first reception healthscreen was conducted appropriately and identified that the man had asthma and was prescribed antidepressants. Both medications were prescribed to him that same day. The man said that he had a history of excessive alcohol use and also used drugs. Although Nurse A, who conducted the healthscreen, said that she knew the man had only been released from prison on 6 May, this was not recorded anywhere on his medical record. On the basis of the information gathered during the healthscreen, the nurse referred the man to the doctor.

88. In later appointments with healthcare professionals, the man either did not reveal that he had so recently been released from prison or lied about how long he had been at liberty. As a result, both the doctor and the substance misuse nurse believed that he had been drinking excessive amounts of alcohol for about a month. The clinical reviewer notes that, due to the short time he spent at Pentonville prior to his death, healthcare staff had not yet received his community medical records or those from HMP The Mount. She writes, however, that since the man's death, Pentonville has begun using a different electronic medical record system, which allows staff to search for previous prison records more easily. We conclude, however, that on the basis of the information he provided, staff were correct to immediately place the man on the alcohol detoxification programme. The clinical reviewer notes that chlordiazepoxide has a similar affect on the mind and body to sedative medication. When taken by a patient who is not experiencing alcohol withdrawal, it might lead to feelings of light headedness, confusion and drowsiness. There is no evidence to suggest that it might lower the mood of the patient or lead to depression.

89. In the first three days in prison, the man missed five doses of chlordiazepoxide (the alcohol detoxification medication). He missed the doses while he was in a cell on G2, the vulnerable prisoner's overspill. Nurse C suggested that he missed being unlocked for medication because staff on G1 (the main VP landing), did not realise that the man also needed to be unlocked. She explained that the new electronic system meant that such errors did not occur any longer. Staff also said that prisoners are encouraged to take responsibility for their own medical treatment, as they would in the community. It seems that the man did not tell wing staff that he had missed his medication. This may be because he was not experiencing any withdrawal symptoms and so was not anxious to take it. Nonetheless, the introduction of a new system that avoids confusion about which prisoners need to be unlocked for medication is a welcome advance.

90. The clinical reviewer writes that, in general, the standard of record keeping in the medical record was adequate and appropriate. However, she notes that some of the record contained hand written information and signatures, particularly on prescription charts. It was not always clear whether the prescription chart had been signed by a member of staff (and certainly it was not possible to identify the individual signing) or whether the man had not collected his medication. As a result, the clinical reviewer makes the following recommendation:

    The head of healthcare should ensure that a specimen signature sheet is available for every relevant member of staff.

Assessing the man's mental health and risk to self

91. During his short time at Pentonville, The man had meaningful contact with five members of healthcare staff: Nurse A, Prison Dr A, Nurse B, the substance misuse specialist doctor and Nurse D. During the various examinations and assessments he underwent, he was asked direct questions about thoughts of suicide or self harm. The substance misuse specialist's assessment was particularly focused on assessing the man's mental health. All of the healthcare staff interviewed as part of this investigation agreed that the man gave them no cause to worry about him. Although he disclosed a history of depression, he consistently denied having any thoughts of suicide. He was prescribed antidepressants on his arrival.

92. The substance misuse specialist doctor wrote that the man showed and described some of the signs of depression, including poor sleep, lack of concentration and poor appetite. However, she saw no signs that he posed a serious risk to himself. The clinical reviewer concludes that the man received appropriate mental health care while at Pentonville.

93. Once in the segregation unit, the man was subject to regular monitoring. Segregation staff interviewed agreed that they had no reason to think that the man might act as he did. All of those staff interviewed were clear that, had they any concerns, they would have placed the man on an ACCT plan immediately.

94. With the great benefit of being able to review all of the information available, we note that the man possessed some "risk factors" that might have made him vulnerable. He had been charged with very serious offences, which, if proved, would undoubtedly have led to a lengthy prison sentence. He was moved to the segregation unit because of the nature of those offences and the fact that he was potentially a category A prisoner. He must have realised the seriousness of the situation. The man said that he was estranged from his family and during his time at Pentonville, he did not speak to or receive a visit from any friends or family. He also had a history of alcohol and drug misuse. However, on the basis of the available evidence, it seems that the man chose to portray himself as untroubled and at ease.

The decision to give the man a radio and flex

95. The man's mother asked why her son had been given a radio with a flex, which he used as a ligature. Segregation staff explained that the man was not being segregated as a punishment, but because he was potentially a category A prisoner, in line with local policy. The staff also said that they do what they can to lessen segregated prisoners' feelings of isolation, boredom and frustration, including, where appropriate, issuing them with a radio. The man asked for a radio on 14 May. Given that he had been fully compliant and there were no concerns about the risk he posed to himself or to others, they agreed his request.

96. We have commented in the past about the potentially psychologically damaging nature of segregation. We agree that providing a segregated prisoner with a radio can help to relieve some of the stresses of being segregated.

97. Staff explained that the segregation radios (which are standard issue, purchased from the high street) run either on battery or by being plugged into the in-cell electricity points with a detachable flex. They said that prisoners used to have to purchase batteries and they complained about the cost. Staff also noted that the large batteries required could be used as a weapon. As all cells in the segregation unit have in-cell electricity, the radios are now issued with the flex – unless there is any reason not to. SO A, and the duty governor, who agreed the man's request, said that they had no reason to think that he could not be given the radio and the flex. We accept this to be the case and that a risk assessment based on the information available and the man's demeanour was made, we therefore make no criticism of their decision. It is also important to note that the man had other items in his cell that night (his bed sheet for example) which he could have used to harm himself.

Segregation checks

98. SO A and Officer B told the investigator that for the first 24 hours a prisoner spends in the segregation unit they are checked once every 30 minutes. After 24 hours, the checks reduce to once an hour. On the evening of 14 May, Officer B said that he reduced the level of checks on the man to once an hour. He signed the man's segregation book to indicate that he had checked him once an hour between 9.00pm and midnight. The CCTV footage of the segregation unit showed that he checked the man at 11.02pm and then again at 12.31am – a gap of 90 minutes.

99. Pentonville's local segregation policy does not include any guidance on the frequency of checks. The governor in charge of the segregation confirmed that the checks staff described are accepted staff practice rather than formal policy. It is our view that conducting regular checks on prisoners in the segregation unit is good practice and should form part of the prison's local policy. Because the frequency of checks required is not included in the written policy, we do not criticise Officer B for not, in fact, checking the man for over an hour. However, we make the following recommendation:

The Governor should amend the local segregation policy to include the required frequency of checks on prisoners.

The emergency response

100. Officer B looked in the man's cell at 12.31am and realised that he had a ligature around his neck. He used his radio to alert the prison to a Level One emergency (the correct code in the circumstances). SO B was on the scene in less than one minute and, according to the CCTV footage, he and Officer B were in the cell by 12.32am and began CPR. At that point, six members of staff had arrived at the cell to assist. Three nurses arrived at 12.33am, with emergency medical equipment. An ambulance was requested swiftly and paramedics were on scene by 12.44am. Unfortunately, despite all efforts, the man could not be resuscitated.

101. Nursing staff told us that, having learnt from previous emergency situations, the gates that divide the wings at Pentonville are now left open at night. Undoubtedly, this enables healthcare staff to reach a medical emergency more quickly. We are pleased that the Governor has made this sensible decision.

102. The CCTV footage shows one of the nurses leaving the scene, apparently to collect more equipment. Neither of the nurses interviewed could recall this happening, although Nurse C thought perhaps someone had gone to collect the defibrillator. The nurses interviewed said that they had easy access to all of the equipment they needed to help the man. Clearly, it is desirable that all appropriate equipment is taken to a healthcare emergency. In the absence of any more information, we make no further comment.

103. The clinical reviewer and we find that the staff response to the incident was speedy and efficient. The prison and nursing staff showed excellent teamwork and it is clear that all of those on duty that night were well aware of their responsibilities under the prison's local contingency plans. Undertaking CPR, particularly when it is ultimately unsuccessful, is a traumatic experience and those staff who were involved in the attempts to resuscitate the man should be commended for their efforts. We are sure that the Governor and head of healthcare will wish to pass on our commendation to the staff involved.

CONCLUSION

104. The man had only been released from prison two days before he was arrested and charged with very serious sexual and violent offences. Once at Pentonville he was moved to the segregation unit because the nature of the offences meant he might be a category A prisoner. On his fifth night in prison, a member of staff carrying out routine checks found him with a ligature around his neck.

105. There is no doubt that the man knew the seriousness of the situation he was in. If found guilty of the offences he would have faced a lengthy sentence as a vulnerable prisoner. He had a history of depression and substance misuse and was prescribed medication for both. Despite these factors, staff said that they saw no signs that he was struggling to cope and he came across as a confident man. We make two recommendations as a result of this investigation but do not believe that either would have changed the outcome.

RECOMMENDATIONS

The NOMS response to the recommendations is recorded in italics below each recommendation.

1. The head of healthcare should ensure that a specimen signature sheet is available for every relevant member of staff.

   This recommendation has been accepted. NOMS clarified that "since July 2011 we moved to electronic administration of medication so we do not have paper prescriptions any more. Staff have to log onto the system with their own password and the system records who is the person administering so it can be identified at all times."

2. The Governor should amend the local segregation policy to include the required frequency of checks on prisoners.

   NOMS has accepted this recommendation, noting that "the segregation policy document will be amended to reflect required timings and regularity of staff checks on prisoners." This action is to be completed by January 2012.