

**INVESTIGATION INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF A MAN AT HMP
PENTONVILLE IN JUNE 2005**

**Report by the Prisons and Probation Ombudsman for England and
Wales**

January 2006

This is the report of an investigation into the death of a man who died on 12 June 2005 in HMP Pentonville. The man was found hanging in his cell. He was 24 years of age. The toxicology report reveals that he had alcohol in his bloodstream.

I would like to offer my sincere condolences to his family on their loss.

The investigation was conducted on my behalf by one of my colleagues, and a family liaison officer from my office, visited the man's family. Along with the investigator she also met with the man's partner. In both meetings, the aim was to discuss the investigation and to elicit any questions they would like answered.

I thank the Governor of Pentonville and his staff for their assistance during the investigation. I am particularly grateful to the governor who acted as the local liaison officer. Thanks are also due to the doctor from Islington Primary Care Trust who conducted a clinical review of the man's healthcare needs and how they were met.

The man was in prison just 36 hours before he died and few staff or prisoners had any contact with him. Every effort was made to save him. However, there are improvements that can be made at Pentonville in respect of reception and the first night centre.

Another prisoner sadly died apparently at their own hand in Pentonville on another wing two days after the death of the man who is the subject of this report. The report into that death will consider if there are any lessons that can be drawn together from both investigations.

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Prisons and Probation Ombudsman

January 2006

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Summary

The man was just 24 years old when he died at Pentonville prison on 12 June 2005. He had been in custody only 36 hours.

When he arrived at Pentonville, his Prisoner Escort Record (PER) had a box relating to his risk of suicide and self-harm ticked. This was because he had previously taken an overdose of medication.

He underwent a healthcare reception screening. The nurse who completed this found it difficult to persuade him to talk openly. The nurse was concerned by his low mood and so asked the doctor to see him. The doctor assessed him but did not ask about any mental health issues. However, he did consider the nurse's concerns and requested that he be placed in a shared cell.

On the first night centre, he shared a cell with prisoner A. He reported that the man did not say much. The only thing he really talked about was being concerned he was not going to see his daughter, and thinking he might receive a long sentence. He spent most of his time laid on his bunk.

Toxicology reports show that at some point, probably on Saturday 11 June, the man consumed a large amount of alcohol. This was very out of character for him. On learning this fact my investigation team returned to Pentonville. They reinterviewed the man's cellmate and examined security information. Prisoner A could shed no light on the situation. He did not see the man consume any alcohol or anything unusual and reported that he was not aware how to obtain it in the prison.

The amount of alcohol that the man consumed is likely to have altered his mood, possibly making him feel very low.

The man was found hanging by his cellmate when he awoke on 12 June just before 6am. He raised the alarm by pressing the cell bell. Help arrived quickly and attempts were made to save his life. Paramedics arrived and pronounced death. It is thought the man had been dead for some time.

Due to the short period of time he was in custody, it was difficult to find anyone who knew him, or had a good understanding of any problems he faced. It also appears he was reluctant to talk with staff.

I conclude that the first night centre affords an unwelcoming environment and there is much that can be done to improve it. Communication between reception and the first night centre also needs to be enhanced.

My report makes four recommendations.

Investigation process

I appointed one of my colleagues to conduct the investigation on my behalf, and she was supported by two other members of the investigation team.

The team visited HMP Pentonville, where they met the Governor. They visited the cell where the man was found. They also met with members of the local branch committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB).

Notices were issued to both prisoners and staff, inviting anyone whom might have information relating to the man to make themselves known to the inquiry.

Along with the investigator, one of my family liaison officers visited the man's family to ascertain their particular concerns and questions about the investigation.

The investigation team interviewed prison staff and prisoners both formally and informally.

The team examined the man's prison record, medical records and a series of prison documents. They also assessed the care that he received against Prison Service orders and policies.

A clinical review of his health care whilst in prison custody was undertaken by a doctor from Islington Primary Care Trust.

Background

The man was born in 1980, and was 24 years old when he died. Prior to going into Pentonville, he was employed as a security guard. He lived with his partner and young daughter. This relationship was a turbulent one, and coming to an end. He had made arrangements to live elsewhere whilst maintaining contact with his daughter.

On Friday 10 June, he was remanded into custody for alleged offences against his partner.

He arrived at Pentonville at approximately 3.30pm. On his Prisoner Escort Record (PER), the "risk of suicide" box had been ticked. This is because he disclosed to the police that he had previously attempted suicide. The man saw an officer who explained what was going to happen, and recorded his possessions. He was then strip searched, given some prison issue clothes and placed in a holding room to wait to be seen by the nurse.

The reception nurse completed a health screen with him. During interview, the nurse explained that he had seemed particularly low in mood. He would not answer some questions and was generally reluctant to talk. When the nurse asked if he had ever self harmed, he initially did not answer, then replied that he had previously taken an overdose. When the nurse tried to find out more, he was again reluctant to answer. The nurse found his low mood and reluctance to answer questions a little concerning, and appropriately thought it best that he see the doctor.

The reception nurse accompanied him to see the prison doctor, and said in interview that the man was different with the doctor and did not appear as low. The doctor asked no further questions relating to self-harm or suicide. The doctor marked on his Cell Sharing Risk Assessment that he should share a cell. When asked in interview, the doctor said that everyone was to share a cell on their first night unless they were considered a risk to others. This was a lesson learned from a previous death in custody. Otherwise, the man was a healthy young man who was fit, did not use drugs, and did not regularly drink alcohol.

The man was taken to the first night centre and allocated his cell on A3 landing. He was given a reception pack. Wing staff were not aware that he had previously attempted suicide, or that his PER form was marked as a risk.

Prisoner A was allocated to the same cell as the man who died. He arrived at the cell a couple of hours after the man. He reported that the man was quiet but seemed okay.

Prisoner A reported that the man did not say much, he mainly lay on his bunk. The only thing he really spoke of was his concern about not seeing his daughter.

That night, the prison officer was working in the security department. Part of his role is to complete a Security Collator's Initial Assessment on new prisoners. In order to complete this form, he must consider documentation from courts, police and the PER form. He completed the assessment regarding the man, and, noting that the suicide marker had been ticked on the PER form, contacted the night orderly officer who reported that this was not a requirement, but that the prison officer is a particularly experienced and thorough in his work. The man was one of two prisoners who had a marker on their PER. The orderly officer then checked the names were not on the list of those on F2052SH's (a form used to monitor and support those at risk of suicide or self-harm). He then checked their details on the Inmate Information System, and saw that the man had been in Pentonville previously for a brief period.

The night orderly officer went to A3 landing and opened the flap on the man's cell. The man looked up and the officer asked him if he was okay. The man responded that he was fine. He checked once more later in the early hours of the following morning. The man was asleep.

The following day (Saturday), the man stayed mainly in his cell. He underwent an induction assessment with the induction officer, who is the team leader of the induction group. The officer did not specifically remember him as he conducted a lot of interviews that day and the man did not present any immediate problems. Referring to the assessment, he reported that the man had said he did not have any mental health issues or medical issues that needed addressing. He did not cause any concern.

The man also made a telephone call on the Saturday afternoon and spoke with his brother. He asked for telephone numbers of other family members, and told his brother his court date was 24 June. He also told his brother that his former partner's father was in Pentonville as well, but that he did not know what wing he was on. The man's brother was concerned about this. The man said that if he was found guilty his solicitor had said that he could be sentenced to years rather than months. His brother told him to go to the gym and read books, and that the 24th was not far away. He also reassured him that he would take care of things outside of prison and look into visiting rights for his daughter.

It is unclear whether the man took lunch, but he did collect his meal from the servery on A2 landing on Saturday evening. Another prisoner on the wing recalled seeing him at the servery area. The man had asked the prisoner where to collect food. He said that the man did not appear to mix with other prisoners and that he did not have any further contact with him.

That evening, the prisoners were locked behind their doors from approximately 7pm. The man was in his cell with his cellmate. There was no radio or television. There were some newspapers, but his cellmate reported that the man, in the main, just lay on his bunk looking at the ceiling. The last conversation they had was the man enquiring about a small piece of sheet that was attached to the window bars outside the window. Prisoner A said it

was probably prisoners trying to keep their milk cool by tying it outside.
(Prisoners are given breakfast packs each evening, including some milk.)

The man wrote a letter to his family. It was a rather confused letter. On the one hand, he asks that his family make sure he has a suit ready for his court appearance. But at other times in the letter he expresses a sense of hopelessness.

Prisoner A said he fell asleep around 10pm. He said he is a heavy sleeper and slept through till the morning.

At some point, almost certainly on the Saturday, the man consumed a large amount of alcohol. His cellmate says he did not see him drink anything, and was not aware how he could have obtained the alcohol.

12 June

The man's cellmate woke shortly before 6am. He rolled over and saw the man hanging from the window bars with a bed sheet around his neck. He immediately rang the cell bell. A wing officer was patrolling and was near the cell when the bell was pressed so attended the cell almost immediately. Prisoner A recalls the officer shouting "get an ambulance quick". The officer put a "code one" out over the radio. (A code one signifies urgent assistance required because of a medical emergency.)

At night, the prison is in patrol state. This means that only the night orderly officer has access to all keys. Other staff have a cell key in a sealed pouch which is only to be used in emergencies under certain guidance. The gates from the centre of the prison onto the two's landing are left open to allow staff free movement over all floors of an individual wing. At the time of the radio call, the night orderly officer and a second wing officer were located on the centre, and ran to cell A3 17 where the man was located. They reported that they were there within seconds.

The night orderly officer opened the cell. The two wing officers lifted the man whilst the orderly officer removed the ligature. The orderly officer remembered that the ligature was made from a whole bedsheet and the ligature knife could not cut through it, so he had to lift the bedsheet over the man's head. They placed him on the floor. The night orderly officer remembered that the man felt very stiff. By this time, the duty nurse had arrived. He had been based in the treatment room on the centre, and picked up some emergency equipment; the resuscitation bag, the ECG machine and oxygen.

The officers moved prisoner A into the cell next door while they dealt with the emergency.

The duty nurse recalled checking for an airway and any signs of life. He observed that rigor mortis had set in and that the man was cyanosed (a blue tinge to the skin) and cold. There was no heartbeat, there was no pulse, and there was no respiratory effort. The nurse still attempted cardio pulmonary resuscitation (CPR), beginning with a large thump on the sternum. He continued CPR until the paramedics were in attendance.

Once the ambulance arrived, the paramedics used the ECG machine which recorded that there was no heart output. The duty nurse reported that he recalled the ambulance crew felt that the man might have been dead for approximately six hours due to the level of rigor mortis. The paramedics pronounced him dead, and the cell was sealed. The police arrived at 6.45am. The prison doctor was called and arrived at approximately 9am and certified the man's death.

Contingency plans

The duty governor arrived and took charge of the situation. He ensured all documents relating to the man were collected. The man had recorded his grandparents as the people to contact in an emergency. The duty governor telephoned the man's family.

All contingency plans were appropriately followed. The duty governor conducted a hot debrief with staff involved. All staff reported feeling supported and said they knew how to access help.

The governor phoned a member of staff who was particularly affected, later in the day, to again check how he was feeling. He also followed up on staff the next day.

Contact with the man's family

The duty governor broke the news by phoning the man's grandparents at their home at 6.40am in the morning. He said he decided to phone, as he knew the importance of the family being contacted as soon as possible. He also did not feel in a position to leave the prison, especially given that it was a Sunday and there were fewer staff on duty than usual.

The man's grandfather telephoned his mother. She phoned a directory enquiries number to obtain the number for Pentonville and then had to go via the switchboard to contact the governor. By the time she spoke to the duty governor, it was 8.45 am. She was concerned as she was told that they were still waiting for a doctor and the police to arrive, and she thought this was a long time as her son had been found at 6am.

The mother wanted to see her son's body that day and was very upset by the initial response from the Coroner's office that it could not be done on a Sunday. She finally managed to see her son at 6pm on the Sunday evening.

The duty governor visited the family the following day along with the prison chaplain, and delivered the man's possessions.

His mother visited the prison, was met by the in charge governor, and was able to meet and speak with her son's cellmate.

Background details of HMP Pentonville

Pentonville was built over 160 years ago. It is a local prison which accepts all suitable prisoners from courts within its catchment area (North East London). It has a certified normal accommodation of 897 prisoners, but an operational capacity (maximum crowded capacity) of 1,189. Although much refurbishment has taken place, the original four residential units are much as they were when the prison opened in 1842.

The First Night Centre is housed on A wing, landing 3, and is staffed by a group of officers who are responsible for the delivery of the prison's induction programme. They also ensure that prisoners receive 'First night welcome packs', are allowed to make a telephone call, have a shower and are allocated appropriate accommodation. Medical staff also take part in the First Night Centre process, with all prisoners receiving a Reception Healthcare Screen and provided access to the Duty Medical Officer.

On Friday 10 June, over 200 prisoners passed through reception (this includes those going either to or from court, those released and those newly received). The man was one of 30 new prisoners that day.

The man was the fourth prisoner to die apparently by their own hand in Pentonville since June 2004. All died in their first few days in custody. Sadly, another prisoner died three days after the man who is the subject of this report.

Pentonville has worked hard to improve practices since these deaths and a review of their procedures was undertaken by the National Offender Management Service's Safer Custody Group. Most of the recommendations from this review have been implemented, and there has been a great emphasis on safer custody led by the head of residence. I recognise this much needed improvement. However, there is still a long way to go.

Findings and Conclusions

Reception

The investigation team found Pentonville's reception area to be clean, but basic. On the day that the man came into Pentonville, there were 200 movements of prisoners in and out of the prison. The demands on staff working in reception with this number of prisoners passing through need no elucidation.

A senior officer completed the first part of the man's cell sharing risk assessment. This assessment is used to assess the risk a prisoner may pose to others. He assessed him as medium risk. In interview, he reported that this was because part of the man's alleged offence involved false imprisonment. Later in the interview, he mentioned that potential self-harm issues formed part of this decision as well.

- Healthcare assessment

The reception nurse acted appropriately by referring the man to the doctor when he had concerns. However, the doctor failed to ask further questions relating to the man's mood, feelings or previous overdose. The clinical reviewer comments that the prison doctor had received no specific training in mental health assessment, either before coming to work in the prison service or during his seven years of working there. He was not aware of the existence of Pentonville's local suicide and self-harm prevention policy.

As the prison doctor has been employed in a locum capacity throughout his service at Pentonville, he has not been entitled to any paid time for study leave or continued professional development. Although he has had annual appraisals, there does not appear to be a mechanism for linking development needs with any actions. There do not appear to be arrangements in place for regular team meetings within the prison service, nor systematic clinical support for medical officers.

It is the responsibility of the Prison Service to ensure that doctors working in prison have the training and skills necessary for their role, whether they are in substantive or locum posts. It does not appear that sufficient attention has been paid to the doctor's training needs in respect of mental health, and risk of self-harm assessment. I therefore endorse the following recommendation from the clinical review;

I recommend that Pentonville ensures that training and clinical support is given for prison doctors as required. This responsibility extends to doctors employed on a locum basis, as well as in substantive posts.

- Decision making regarding opening a F2052SH

The standard documentation for the First Reception Health Screen suggests that, if a prisoner has a relevant history of self-harm, consideration should be

given to opening a F2052SH. This could have been done at any time by any member of staff who had concerns. If this had happened in the man's case, he would have had more frequent observation and monitoring during the period that the F2052SH was open. However, assessment of risk of self-harm is difficult and often subjective.

As the clinical review shows, the recent National Institute for Clinical Excellence (NICE) guidelines on self-harm consider in some detail the risk factors for repetition of self-harm. Applying these risk factors to the man, of the ten factors suggesting increased risk of non fatal self-harm he had three (possibly four), and of the ten factors suggesting increased risk of fatal self-harm, he again had three (possibly four). In practice, risk assessment is informed initially by consideration of known risk factors, and is necessarily in part a subjective exercise. These judgements can never be foolproof. I note the clinical reviewer's assessment that there are insufficient grounds to suggest that those interviewing and assessing the man who died should have opened an F2052SH.

- Referral for mental health assessment

The standard documentation for the First Reception Health Screen directs that if a prisoner answers 'yes' to the question about previous self-harm outside prison, he should be referred for mental health assessment. The reception nurse noted the previous attempt but did not refer him for a mental health assessment, although he did refer him to see the doctor that same evening. The prison doctor did not discuss the man's previous self-harm attempt with him, and did not consider he needed referral for mental health assessment (although, by his own admission, he did not explore the man's mental state with him).

In this case, referral to the mental health team for a mental health assessment probably would not have affected the outcome, as such an assessment would not have taken place for several days. However, the directions in the First Reception Health Screen about who to refer for a mental health assessment were not followed. In her clinical review, the doctor in charge found that it was accepted practice that there is room for discretion in individual cases. This situation needs clarification.

- Communication issues

There was a lack of communication between departments regarding the man who died. He had a suicide marker ticked on his PER form. The reception nurse felt he was particularly low in mood. He had also been charged with an offence against his partner – a factor known to increase risk. Although none of this means that a F2052SH should have been opened, it is important the information is shared with wing staff.

The local induction policy states that;

4.1.1 Reception Staff will photocopy all available information and pass it to Induction Staff for use with initial interviews.

I would go further than this and expect that any concerns are also recorded such as low mood, unresponsiveness etc. Some ten per cent of self-inflicted deaths occur within the first 24 hours in custody, and 21 per cent within the first week. It is important for staff to be aware of all forms of risk and not merely have regard for those prisoners with active suicidal intent.

It does appear that the man had little personal or meaningful interaction with anybody, particularly staff.

The report of the most recent inspection of Pentonville by HM Chief Inspector of Prisons commented that there was no formal expectation for induction staff to check information contained in the admissions initial information pack. If staff had been aware of the issues, if risk factors had been recorded in his file at each stage of the reception process, and if it had then been taken to the first night centre, they would have been more likely to have attempted to engage with the man. If someone presents risk factors, the information should also be written in the handover book on the first night centre so staff coming on duty are made aware of particular issues relating to specific prisoners.

On the man's first night, the prison officer, who was based in security, contacted the night orderly officer to provide information about prisoners whose PERs had ticks. This led to the night orderly officer checking on the man twice during the night. Whilst, I commend these two members of staff, this information should have been acknowledged by wing staff at the point of the man's transfer to the first night centre from reception.

I recommend that any factors relating to a prisoner's risk should be noted in his wing file at reception. These issues should also be recorded in the handover book on the first night centre.

First night and induction

The first night centre gives me some cause for concern.

There are many positive aspects to first night arrangements. A member of chaplaincy visits daily, as do Listeners (prisoners trained by the Samaritans). The Listeners are clearly visible as they wear orange t-shirts.

Furthermore, it is pleasing to see that consideration has clearly been given to improvements following recommendations in previous death in custody investigations. The staffing levels at night are being increased. It is also usual to have prisoners share a cell on their first few nights in custody unless they are considered a risk to other prisoners. The induction programme has been improved and is under continual assessment.

However, the first night centre is a cold and unwelcoming environment. (I am conscious that its previous location on E wing was also criticised for being unfit, and that - given the age and layout of Pentonville – nowhere else

immediately presents itself.) My investigation team found the cells to be bleak, and there is no in cell electricity meaning prisoners do not have access to televisions or radios. Provision has been made for in cell electricity to be installed, but this is likely to take a year to complete. I particularly regret that there is no provision for radios, given that prisoners are usually locked in their cells from 7pm with no other distraction.

The Chief Inspector of Prisons had similar concerns about the first night centre. The inspectorate found that only 53 per cent of prisoners reported feeling safe on their first night in prison compared to 70 per cent in other local prisons.

Ideally, a new first night centre to be built. However, I appreciate this is unlikely to occur for several years. However, immediate action at low cost can be taken to improve first night arrangements. For example, duvets can be used rather than blankets. An effective cell-cleaning programme can be introduced to ensure that cells are clean when new prisoners enter them. A light coloured paint can be used on the wing and in the cells, and some pictures can be put on the walls of the landing.

I recommend the urgent consideration of action to improve the physical condition of the first night centre and in cell facilities, including completing the in cell electricity programme as speedily as possible.

Alcohol

Following the man's death, a post mortem was conducted and toxicology tests undertaken. The test results took some time to be processed. They indicated that the man had consumed a large amount of alcohol. This was very out of character for him. The amount is likely to have caused an effect on his mood. Another prisoner died two days after him, apparently at his own hand. He too had consumed alcohol. The investigation team reinterviewed prisoners and examined security incident reports. Prisoner A said that he did not know how to get alcohol in Pentonville, or how the man had, and that he had not seen him consuming any.

There was no indication from the security reports that there is a problem with the production of alcohol in Pentonville or that any had been found on the first night centre in the previous 12 months.

Furthermore, there was no evidence of any container in the man's cell which may have contained alcohol.

The effect of alcohol had the potential to alter his mood, perhaps making him feel particularly low.

It is manifestly of concern that alcohol was available to him, particularly as he had only been in prison for a very short time and was based on the first night centre. Prison-brewed hooch represents a real threat to health and it is

important that the Governor investigates the extent of production of alcohol in Pentonville.

I recommend that the Governor investigates the extent of alcohol production in Pentonville and establishes a plan to deal with the findings and to provide continued monitoring.

Potential contact with the father of the man's alleged victim

The father of the man's alleged victim was also located on A wing, on the floor below the man's floor. The man's family were understandably concerned of the potential contact between the two, and what may have been said.

The victim's father insists he did not know the man was in Pentonville, although he knew that he had been charged with an offence against his daughter. The first he knew of him being in Pentonville was when he saw the notice regarding his death. He then identified himself to wing staff and police as knowing him. The victim's father cellmate confirms that he never spoke of the man who died being in Pentonville until he saw the notices.

The man did not go on association or for outside exercise in his short time at Pentonville. When meals were served, they go to each landing in turn. It is possible but not especially likely that the two men could have seen one another at this point.

During the man's phone call to his brother he mentioned that his partner's father was in Pentonville, but he did not know which wing he was on. This phone call was made on Saturday afternoon.

Staff were not aware of the relationship between the man and the father of his alleged victim. Furthermore, the man was asked on his induction if he had any particular concerns, and he replied "no".

Crisis Management

When prisoner A woke to find the man hanging he raised the alarm by pressing the cell bell. This was responded to quickly by the wing officer, who in turn radioed for urgent assistance. Staff were present in seconds, including the duty nurse. This is because Pentonville has two nurses on duty at night: one on the healthcare centre and one situated in the main part of the prison to enable a quick response to wings.

The duty nurse acted admirably in attempts to resuscitate the man despite the presence of rigor mortis.

Furthermore, all night staff carry fish knives (to cut ligatures) as standard issue. I consider this to be good practice.

Breaking the news to the man's family

The duty governor broke the news by phoning the man's grandparents at their home at 6.40am in the morning. I understand the governor's reasoning (making sure the sad news was passed on quickly, and not feeling able to leave the prison on a Sunday morning when fewer staff were on duty). However, I remain of the view that it is best practice wherever possible for a governor to visit in person to break the news.

Summary of Recommendations

I recommend that Pentonville ensures that training and clinical support is given for prison doctors. This responsibility extends to doctors employed on a locum basis, as well as in substantive posts.

I recommend that any factors relating to a prisoner's risk should be noted in his wing file at reception. These issues should also be recorded in the handover book on the first night centre.

I recommend the urgent consideration of action to improve the physical condition of the first night centre and in cell facilities, including completing the in cell electricity programme as speedily as possible.

I recommend that the Governor investigates the extent of alcohol production in Pentonville and establishes a plan to deal with the findings and to provide continued monitoring.