# INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING

# THE DEATH OF A MAN AT

# HMP PENTONVILLE ON 25 JUNE 2004

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

**March 2005**

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Report by Senior Investigating Officer

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Pentonville in June 2004.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. The bulk of the investigative work has been conducted on my behalf by the senior investigating officer, from London Area Office. A clinical review was conducted by the Section Head, Substance Misuse Team from Prison Health. I am very grateful to all members of the team for their meticulous work.

I have structured this report so that the senior investigating officer's investigation can be separately identified.

A colleague from my office liaised with the senior investigating officer throughout this investigation and visited HMP Pentonville when the investigation commenced. My investigator also contacted the man's sister and informed her about the investigation. The man's sister had no specific questions about her brother's death. I would like to offer my condolences to the man's sister and to his family and friends.

The man's death was the first self-inflicted death at Pentonville prison since the Ombudsman was passed responsibility for the investigation of deaths in custody. Sadly, two more prisoners died in October 2004. The reports into those deaths will include an overview of all three deaths to see if any lessons can be drawn to try to prevent similar tragedies in the future.

Unfortunately, the man's story is not an uncommon one amongst those who appear to have taken their own lives in prison. He was familiar with prison and familiar with staff at Pentonville. The man had a long history of poly drug and alcohol abuse. It seems he often had hopes of putting his life back on track but found this task incredibly difficult and returned to drug and alcohol abuse. It may be worth noting that one of the drugs he used was Crack cocaine, the withdrawal from which can induce short, sudden periods of deep depression. He was probably suffering withdrawal symptoms from alcohol and tobacco too. The man died on his first night in prison custody.

The senior investigating officer from the London Area Office places particular emphasis upon the staffing on Pentonville's first night centre. However, he judges that the allocation of the man to a cell where he was the only occupant and the use of the police to inform relatives of his death were appropriate. I take a somewhat different view of the matter. In particular, I am disappointed that a prisoner coming off drugs should have been placed in a cell alone, with neither a radio nor television. It is good practice for prisoners on first night centres to have access to a television in their cell. It may aid distraction from their anxieties and provide entertainment during this period when some prisoners are particularly vulnerable. Where it is not possible for cells to have televisions, a radio should always be provided.

**STEPHEN SHAW CBE**
**PRISONS AND PROBATION OMBUDSMAN**
**JANUARY 2005**

## Summary

This is the report of an investigation into the death of a man at HMP Pentonville in June 2004.

The man had spent one night in police custody before receiving a sentence of three months and being taken to Pentonville prison. On the Prisoner Escort Record (PER), he was identified as being at risk of suicide or self-harm. This was given consideration by the reception nurse but he was not put onto a F2052SH (a mechanism to care and monitor those who are considered at risk of suicide or self harm). The nurse who screened him said that he expressed no suicidal thoughts to her and that, because she knew him from previous periods in custody (and he had never been on a F2052SH), she did not feel that extra monitoring was necessary.

During the reception process, the man was identified as a poly drug abuser and as suffering from Deep Vein Thrombosis in both legs. The nurse referred him to the Doctor who assessed him as needing a detoxification programme and provided him with some medication to help him through the night.

The man was located on the first night centre. It is best practice to locate people detoxing from drugs in a shared cell with another prisoner, risk assessment allowing. In his case, the cell sharing risk assessment did not highlight any concerns, and he was allocated to a double cell. It just so happened that no other newly received prisoner was allocated the same cell that evening and so he was on his own.

Different staff interacted with the man during the evening of the 24 June, some of whom were familiar with him. Staff reported that there was no indication that he might be thinking of taking his own life. An officer on the first night centre was not concerned about him and said that he had been watching the football with other prisoners. The man had appeared happy and cheerful and was having a joke with the others. He seemed unconcerned that he had no cell mate on that first evening and said it would mean he could get “a decent night’s kip now”.

At approximately 5.35am on 25 June, the man was found hanging in his cell. Staff acted quickly and appropriately in attempts to resuscitate him. Paramedics were at the prison within a very short time but they were unable to save his life.

The senior investigator's report makes five recommendations. One of the recommendations concerns the staff complement on the first night centre. The clinical review from the clinical reviewer concluded that given the man’s drug and alcohol addiction, he should have been located somewhere that benefited from enhanced staff supervision. It is clear that the first night centre is not staffed to facilitate this higher level of supervision. The staffing levels at night should be reviewed if prisoners with complex medical needs are to be located there rather than in the Healthcare Centre.

## Senior Investigating Officer's report,
## London Area Office

## Introduction

A.1 On the authority of Mr Stephen Shaw, the Prisons and Probation Ombudsman, an investigation has been conducted into the tragic death of a prisoner at HMP Pentonville.

A.2 The man was found suspended in his cell by a ligature during the prison's morning count of 25 June 2004. He failed to respond to resuscitation techniques carried out by staff and was subsequently pronounced dead by attending ambulance personnel.

A.3 A Lead Investigating Officer tasked to coordinate the investigation on behalf of the Ombudsman's office and a Governor from the HM Prison Service London Area Manager's Office was tasked to carry out the investigation.

A.4 The investigating team would like to thank the Management and Staff of HMP Pentonville for the co-operation they provided during the course of the investigation. Additional thanks are extended to the Principal Officer for the assistance he provided to the team whilst acting as their Establishment Liaison Officer.

A.5 The inquiry team would also wish to extend their thanks to the staff of the Home Office Typing Centre, Queen Anne's Gate, London for the service they provided in the transcribing of all interview tapes.

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. **Investigation Process / Methodology**

B1 On 29 June 2004, upon receipt of the Terms of Reference I attended HMP Pentonville and met with the duty governor on the incident day and with a governor who acts as the establishment family liaison officer. I received a full and in-depth briefing as to the incident and actions taken by the prison in regards to the after incident management, the liaison established with the man's family and of the contacts made with other outside agencies, (Coroner, Police etc.). I provided the establishment with a list of requirements and arranged a further meeting when the investigator from the Ombudsman Office could be present.

B2 On 7 July 2004, accompanied by the Ombudsman Office investigator, I again attended HMP Pentonville and was able to meet with the principal officer, the team's allocated establishment liaison officer. The Ombudsman investigator was fully briefed and we received an update as to the current situation regarding contact with the man's family.

B3 Whilst at the prison we took the opportunity to meet with representatives from the Prison Officer's Association and the Independent Monitoring Board. We advised how the investigation would be conducted and the process of disclosure of the resultant report. The meeting was concluded with the team extending an open invitation to both offices to meet with the inquiry team at any time to discuss issues of concern, should they arise.

B4 The Ombudsman investigator and myself took the opportunity during the course of our visit to plan the investigation strategy, discuss investigation parameters and team member's responsibilities. We took possession of a large quantity of documentation from the principal officer relating to the man's period in custody within HMP Pentonville and were able to study these at length.

B5 We visited the scene of the man's death and were able to gain a briefing as to the area's function and regime. I was later able to speak with staff and prisoners located within the wing to gauge if there were any underlying issues relevant to the investigation. There were none identified.

B6 During the early stages of the inquiry I contacted the Police Officer responsible for investigating the death on behalf of the Metropolitan Police. We were able to discuss

areas of mutual concern and agreed on a protocol for co-operation, which we both found to be extremely useful. The liaison established between Police and the inquiry team proved to be very effective and I hope beneficial to both offices.

B7 In order to determine the level of medical care received by the man during his period of custody in the prison, the Ombudsman investigator contacted the Section Head (Substance Misuse) from the Prison Health Team and requested he conduct a review of the man's Inmate Medical Record. **His findings have been incorporated into this report at section F.**

B8 I studied all documentation obtained and identified who I would need to interview in order to gain the facts of this case. I have formally interviewed ten members of prison staff, with seven further persons having been spoken to and case notes recorded. During the investigation process I spoke with many other persons within the establishment. However, I have considered that these persons were unable to contribute information of evidential value to the investigation.

**HMP Pentonville**

C7 HMP Pentonville was the prototype for a radical design by Major Jebb - after whom the avenue on which Brixton Prison stands was named. Pentonville was completed 150 years ago and has remained in use ever since as a local prison. Although much refurbishment has taken place the original four cellblocks are as they were when the prison opened in 1842.

C8 The prison's regime includes education (full time / part time and evening classes), workshops, training courses and works department. Offending behaviour groups e.g. enhanced thinking skills are available. The establishment also provides special features such as a dyslexia project, an NVQ painting shop and community work by the PE department.

C9 HMP Pentonville has a 24-hour healthcare service supported by a full time senior medical officer, supporting clinical staff, and nurses. Pentonville provides hospital officers, healthcare administrative staff and a pharmacy. The establishment has a Hospital Wing and provides 43 in-patient beds.

C10 Pentonville makes use of NHS services to provide acute emergency general care, mental health services, dental treatment, radiology and access to the full range of specialist services available to the wider public.

C11 Prisoners with a drug problem are identified on reception by health care staff, and by mandatory drug testing. Pentonville is able to provide most treatments needed including detoxification. Arrangements can be made to provide rehabilitation programmes.

C12 The prison has links with various outside agencies e.g. the probation service sits on the drug strategy group, there is a group which represents prisoners' families, and the Rehabilitation of Addicted Prisoners Trust provides drug rehabilitation programmes. The establishment is represented on the Camden and Islington Drug Action Team.

C13 HMP Pentonville is a local prison, which accepts all suitable prisoners from courts within its catchment area (North London). It currently has a CNA of 897 and an Op Cap of 1205. On the night of 24 June 2004 the prison housed some 1138 prisoners.

C14 In the period immediately preceding the incident under report the establishment opened a 'First Night Centre' in E Wing (Attached to end of A Wing). The purpose of the unit was to house all newly received prisoners into the establishment in order that resources could be focused and all prisoners' needs addressed at the point of first reception to the prison. Prisoners would remain on this unit overnight or until processed and then move on to other residential wings throughout the establishment, dependent upon individual needs / categorisation.

C15 The First Night Centre is staffed by a dedicated 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.

C16 On the evening of 24 June 2004, twenty new prisoners were received into the establishment and subsequently accommodated in the First Night Centre.

**Sequence of Events - Overview**

**Reception to HMP Pentonville - 24 June 2004**

D4 The man was received into HMP Pentonville on 24 June 2004 from the Magistrates Court convicted and sentenced to three months imprisonment.

D5 After undergoing the reception process he was located onto the First Night Centre where his induction procedure continued.

D6 The man received a First Reception Health Screening interview conducted by a member of the establishment's Healthcare staff and was identified as having a drug dependency and of suffering from Deep Vein Thrombosis in both legs. He was subsequently referred to the on duty doctor for further examination.

D7 On completion of his examination by the doctor, the man was interviewed for his Cell Risk Assessment and given the opportunity to make a telephone call, have a shower and receive his first night in custody pack.

D8 The man's cell risk assessment did not raise any issues of concern and so he was allocated to E4.01, which although a double cell, was not occupied by any other prisoner at that time. He was the only prisoner allocated to and resident on E4 landing that night.

**The discovery of the man suspended and action taken**

D9 At approximately 05.35 on 25 June, in accordance with the prisons normal night duty procedures, the officer responsible for patrolling that area undertook a security count of E Wing.

D10 Whilst checking the man's cell he observed him suspended by a ligature made from bed sheets attached to the cell window. The officer immediately raised the alarm and called for assistance.

D11 The establishment emergency response procedures were activated and the orderly officer together with other patrol staff from other wings attended the scene. In accordance with the emergency response procedures, nursing staff from the prison

hospital wing attended the scene with emergency medical equipment and proceeded to carry out resuscitation techniques.

D12 A request was made to the London Ambulance Service to attend the prison and within a very short time a fast response unit and then ambulance arrived at the establishment. On their arrival the paramedic personnel were escorted to the scene and took over the medical treatment being administered to the man.

D13 After continuing CPR for a short period the ambulance crew assessed the man's condition and decided that treatment should be discontinued, and he was pronounced dead. Ambulance staff are recorded as having left the establishment at 06.21, 25 June.

D14 At 07.07 that same day the prison's doctor attended E4-01 and confirmed the earlier assessment made by ambulance staff that the man had died.

**Immediate action taken by the establishment**

D15 The management at Pentonville implemented the Prison's Contingency Orders and informed all relevant offices / agencies of the incident.

D16 Staff involved in finding and attempting to resuscitate the man received a hot-debrief and were requested to record statements / Incident Reports of their actions.

D17 The cell was sealed and evidence preservation procedures initiated.

D18 The establishment made contact with the man's family to advise them of the tragedy and appointed a senior manager as the family liaison officer.

## E Findings

### Events leading to the discovery of the man who died

### Reception to HMP Pentonville - 24 June 2004

E1 I interviewed a Prison Service nurse who advised that her main place of duty was in the Prisoner Reception department of HMP Pentonville. She is a trained general nurse and had worked in this area for the previous three years.

E2 The reception nurse explained that the process of receiving new prisoners into the prison had changed recently with the formation of a '*First Night Centre'* (FNC) within E Wing. Prisoners were now received into the prison's reception area from the Court Escort Service and after Court documentation had been checked and prison records raised, they were taken to the FNC for further processing.

E3 On arrival at this location prisoners were allowed to attend to their '*domestic'* issues such as making telephone calls, taking a shower and then allocation to a cell. The reception nurse further advised that, during this period, every prisoner received a medical screening from a Healthcare worker and would be seen by the doctor.

E4 I asked her if she had been on duty on the night of the 24 June, when the man had come into the prison. She confirmed that she had and also that she had conducted the '*First Reception Health Screen'* for him.

E5 She continued by saying that she had known him from previous periods of custody at HMP Pentonville. The man had approached her and requested that he be allowed to watch the football match being shown on television that evening. She had agreed to this request and subsequently screened all other prisoners before finally attending to him.

E6 During her health screen of him that evening, the man had identified that he had a drug dependency and an ongoing problem of Deep Vein Thrombosis (DVT) in both legs. Due to these complaints the nurse referred him to the doctor.

E7 I asked the nurse if she had seen the Prisoner Escort Record form for him on which it had been recorded there had been a marker on his record that he had previously been suicidal. The nurse confirmed that she had seen the form and added that it would have

been a part of her duty to screen these forms. In addition to this she would have spoken to the prisoner during screening to ascertain if he was suicidal.

E8 The reception nurse stated that having spoken with the man that evening he expressed no suicidal thoughts or ideations to her. She had known him from previous periods of custody and recalled that he had never been the subject of F2052SH monitoring. She had no concerns and stated that had she had such concerns she would have passed these on to the doctor for him to address when he saw the man.

E9 I interviewed the prison's doctor, who is a registered medical practitioner who has worked at HMP Pentonville since 1998. He explained that he had been the duty doctor on the evening of 24 June and had examined the man after the reception nurse had screened him.

E10 The doctor recalled that he had been finishing an entry in another prisoner's medical record when the man had entered the examining room. He had asked him to sit down and on completion of making the entry engaged him in conversation. He went through his normal questioning of the patient and recalled that he had known the man from his previous sentence.

E11 The man explained that he had been suffering from DVT and that he had been on medication for this complaint, which he had last taken some five days previously. The doctor advised him that the prison pharmacy was currently closed and that this dosage needed to be confirmed with his medical records at his prescribing hospital the following day. The man accepted this and the doctor advised that he noted from his response that he appeared to be aware that this would be the course of action that needed to be taken before further prescription could be made.

E12 In respect of the man's declared drug addiction, the doctor referred him for a detoxification programme and prescribed him medication to sustain him throughout the night period. The doctor informed the inquiry that tests are currently not available at the time of a prisoner's reception to the prison to identify the quantity of any illicit drug that the prisoner may have stated they had taken.

E13 Current tests available can provide only an indication as to whether there is a presence of controlled drugs within that person's system at the time of testing. Whenever a

prisoner declares that they have been taking illicit drugs or that they are currently under treatment for an addiction, verification can only be obtained by contacting their respective GP or hospital, during working hours the following day. This process is normally completed by staff who work in the detoxification unit.

E14 The prison have been unable to locate the man's treatment card to confirm the medication prescribed / given to him that evening, however the doctor recorded into his Medical Record that he had prescribed him Carbamazepine (200mg bd) and Diazepam (20mg bd). The doctor also explained that he had informed him that he would need to attend the medical station the following morning to receive a further prescription of this medication.

E15 I asked the prison doctor what the man's reaction to receiving this medication was. The doctor replied, '*Yea he knew what we do apparently, and he took the medicine and thanked me and went off*'.

E16 In order to confirm that the man received his medication that night I again spoke with the reception nurse and informed her that I was unable to locate the man's prescription chart. She said, *'He had one, he had one I'm sure because I give him medication myself'.*

E17 I asked her to confirm that the medication had been given in the amounts recorded in the IMR and she replied, '*It was, ….then he asked me, will I get it again in the morning, so I said 'yes, you've been here, you know how, you've been here before so you know the process, you get it in the morning and then through-care will see you after medication'*. The nurse further advised that she had signed the man's prescription chart to confirm that the medication had been given.

E18 The reception nurse went on to say that, after the man had finished seeing the doctor, the next stage in the reception process was that an officer would interview him for completion of his Cell Risk Assessment form. The nurse had input into this form and was required to complete section 3 to indicate to the officer if there were any issues on health grounds that would affect the man's allocation to a cell or type of cell.

E19 On study of the completed document supplied to the inquiry it can be seen that section 3 of the man's form had not been completed. I asked the nurse why this should be the

case. She replied, '*I don't know because we do this for every inmate that comes to see the doctor so I'm surprised that you say this'*.

E20 I asked the reception nurse if throughout her interaction with the man that evening, taking into account his medical problems and her known history of him, if she would have raised any concerns on this form. She again replied, *'If he had said anything, if he was distressed or, we write it, we do document that so that the officer taking him will know that he needs to be observed'.* She advised that in this case there had been no concerns whatsoever.

E21 I spoke with the prison officer who had completed the interview with the man on 24 June for his Cell Risk Assessment form. He found him to be polite and to conform to all the procedures of the risk assessment process. The man displayed no issues of concern and did not stand out from any other prisoner received into the prison that night. The officer stated that he had offered the man a telephone call, but that he had declined this and just requested to be issued with the tobacco from his first night reception pack. The officer concluded by stating that he had limited contact with him that evening and had not met him before that night.

E22 I interviewed the officer on duty in the FNC on the evening of 24 June and he explained that E Wing was his permanent area of work. The officer advised that he had escorted newly received prisoners from the reception area to E Wing that evening and felt that the man must have been one of these prisoners, however his first recollection of him was when he was identified by the nurse as needing to see the doctor. He was one of the last prisoners to be seen.

E23 He said, '*he was sitting on A wing with me and a couple of cleaners and we were all just watching the football and he was happy, he was cheerful, he was having a laugh and a joke, slagging off the game and what have you, like everyone else was doing'.*

E24 The man was one of the last prisoners to go into his cell that evening. The officer had been waiting for him to finish with the doctor and as he finally came out the man joked, '*always the same ain't it gov, it is always the bloody junkies the last ones to go in*'. The FNC officer stated that he had received no special instructions from medical staff as to where the man should be located and so he allocated him to a normal location.

E25 The FNC officer said in response to the man's joke, "*I laughed at the comment 'that's the way it goes mate', and then he asked me 'oh gov any chance of staying out watching the end of the game?' and I said 'no I would love to but I have got to get you banged up' I said 'I've got to get the numbers in*".

E26 The officer continued, that the man replied, '*alright, sweet,' and he said 'can I just get a cup of hot water for a cup of tea' and I said 'yes no problem mate'. So he got some hot water and I said to him 'you are in E401 mate' and he went 'oh lovely', he seemed to know where that was, he run straight up outside the cell, I opened the door and he went 'oh am I on my own?' and I went 'yeah is that alright' and he said 'yes no problem I can get a decent nights kip now' and I went 'alright then mate I will see you later then yeah' and he said 'yeah alright see you in the morning gov'.*

E27 The officer advised that he remained on duty until 21.00 that night. The last time he had seen the man was when he had completed a count of the wing and he had checked his cell. The man had been the only prisoner located on the fours landing. He had checked E4-01 and then worked his way down counting the other landings on route. At the time of checking him he had been making a cup of tea. The FNC officer stated that throughout his contact with the man that evening he had not observed any signs of depression or any indication that he might be contemplating any act of self-harm.

E28 I identified other members of staff working in A & E Wing on the evening of 24 June and in an attempt to ascertain if these officers interacted with the man during that period, I spoke with them. All officers stated that they had no knowledge of him and were unable to offer any information of evidential value to the inquiry.

E29 I interviewed the night patrol officer for A wing who explained that on this particular night, 24 June, he had commenced duty at 20.30. He had arrived on A & E Wing just as the FNC officer was locating the man into cell E4.01 and he recalls this happening, as he was one of the last prisoners to be put in to his cell.

E30 After all prisoners had been located and a count completed by the evening duty staff the night patrol officer stated that he completed his own count to confirm the wing numbers. The man would have been included within this count.

E31 The night patrol officer said that the next time he saw the man was during a patrol at approximately 22.30 / 23.00. He opened the cover of his door observation panel and looked inside. He observed that he had removed his mattress from the bed and had placed this on the cell floor. The man heard the officer looking inside and turned his head to glance at him. The officer then continued with the patrol.

E32 I asked the night patrol officer if he had any further contact with the man during that night and he stated that he had not. There had been no cell call lights or banging, in fact it had been a quiet night all over the wing. The officer advised that as part of his patrol duties he was required to '*peg'* at certain locations throughout the wing. This means, that the officer randomly checks cells to see that the prisoner inside is there and ok. Each of these patrols would have required him to attend E Wing and so he had made regular visits to the area throughout the night. He had discovered nothing untoward during these visits.

**The discovery of the man and action taken**

E33 The night patrol officer stated that on the morning of 25 June he had commenced his morning count of A & E Wings. He started on A Wing, counting all the landings and had then proceeded to E Wing. Starting on the two's landing he progressed up to E4 landing where the man's cell was located.

E34 On opening the cell observation panel cover he looked into the cell and saw that he was suspended by a ligature secured to the cell window. The officer stated that the man was facing away from him and that he observed that his feet appeared to be just touching the cell floor. Initially he was unsure at what he was seeing and so looked again into the cell.

E35 Having realised that his first observation was correct, the officer immediately alerted the control room and other staff by using his radio, calling a Level 1 emergency. He then opened his sealed pouch, which contained a cell key and using this entered the cell.

E36 He used his cut down tool to cut the ligature from the window and lowered him onto the mattress, which was still present on the cell floor. Using this same knife he then cut the remaining ligature from about the man's neck. At this juncture the duty senior officer (SO) and other officers arrived at the scene and took over the incident.

E37 The night patrol officer stated that he felt he was suffering from shock and had to leave the cell. He played no further part in the incident itself, but remained outside the cell while the other officers and medical staff were inside.

E38 I interviewed the duty senior officer who had been the manager of the prison that night. He advised that he had been present on the Centre (All wings branch off from this area) when he had received a radio message, Level 1, from the communications room requesting him to attend E4 landing. The SO also stated that he was aware that healthcare had received the same request. He immediately made his way to the landing and to cell E4-01 where he observed the night patrol officer to be present and the man positioned on a mattress on the cell floor.

E39 The SO explained that he observed the night patrol officer attempting to cut the ligature from about the man's neck. Other officers had attended the scene and entered the cell. He requested the communications officer to contact the London Ambulance Service and

request the attendance of an ambulance. He advised that later he had deployed staff to allow these personnel into the establishment and provide them escort to the scene.

E40 A wing officer was interviewed and stated that he had been working on C Wing when he heard the Level 1 call over the radio. He had also immediately ran to the scene saying that en route he was directly behind the SO and a second wing officer. He confirmed what had been said by the SO regarding the night patrol officer and his actions and was able to add that both the second wing officer and he had entered the cell straight away. On seeing that the night patrol officer was '*Shaken up'* they instructed him to leave the cell.

E41 The first and the second wing officers started to prepare to administer CPR to the man. The first wing officer stated, '*I checked, I felt his skin and he was cold and clammy, so then I checked it for a pulse on his neck and on his wrist and couldn't feel anything and then I wet my hand and put it by his nose to feel for breathing, put my hand on his chest, I listened and couldn't hear anything or feel anything. So I said right he's not breathing and he's not got a pulse, he's basically he's dead, we need to try and resuscitate him*'.

E42 At this juncture the second wing officer attempted to place his mouth cover (One way valve) over the man's face, however the first wing officer stated that the officer was unable to insert the valve into the man's mouth, as it would appear that his lower jaw had locked. They continued to attempt to apply this equipment, without success.

E43 The first wing officer stated that at this point in time the duty nurse had arrived at the scene with medical equipment. The officer said that the nurse supplied a facemask and this was placed over the man's face and was used to deliver air into him. The officer explained that he then stood back leaving the second wing officer carrying out chest compressions, while the nurse administered air through the facemask.

E44 This was continued with the first wing officer and a third wing officer who had also now arrived, eventually taking over from them. These officers continued CPR until the arrival of ambulance crew some moments later. The first wing officer stated that the third wing officer was replaced first, but that he continued to administer chest compressions whilst the ambulance crew connected medical equipment to the man. After they had done this he was replaced by one of the ambulance personnel and took no further part in the medical intervention.

E45 I was able to interview the third wing officer who verified what had been stated by the first wing officer. He also added that he had assisted a second prison nurse to take oxygen to the scene of the incident. A fourth wing nurse who had also attended the scene, was interviewed and stated that on his arrival both a nurse and officers were in the process of delivering CPR. He had entered the cell and removed cell furniture to give the staff more room to operate. He also said that he observed the night patrol officer to be in a distressed state and so later took him down to A2 landing office.

E46 The duty nurse was interviewed and verified that she had attended the incident. She said that on receiving the Level 1 call she had been in the hospital wing. She had collected a small emergency equipment pack and immediately made her way to the scene. The reason she only took the small emergency bag, was that she found the larger one too heavy to carry when trying to get to the location at speed. The nurse stated that the second, larger bag for emergencies was brought to the scene by the second nurse on duty.

E47 The duty nurse stated that she had arrived at the scene and observed staff to be present both in and out of the cell. The man was positioned on the cell floor. She checked his vital signs and found that none were present. She formed the opinion that the man had already died. However aware that she could not formally make this diagnosis, she initiated CPR with the assistance of staff present.

E48 The duty nurse continued to explain that the man's body, '*was extremely cold and clammy, his body was actually quite stiff so by my reckoning and reasoning, he had probably been dead for a while*'. She later said, '*I think what I knew deep down inside is that I was trying to resuscitate a corpse, I mean I was trying to resuscitate a corpse, somebody who had already died, I knew but you have to, do your level best*'.

E49 She concluded by advising that on the arrival of the ambulance staff she handed control of the medical treatment of the man to them and that they continued to work on him before finally stopping. I asked the duty nurse if the ambulance staff had made any comment to her. She replied, '*Yes. The paramedic, one of them said he said, obviously the blood had settled down, the bottom part of the body had, he had probably been dead for maybe about an hour before they arrived. And he said he was going to put that in his report'.*

E50 I interviewed a Prison Service Nurse (PSN), the other nurse on duty that evening. She confirmed that she had attended the scene of the incident with the second larger medical response bag. She had arrived at the scene to observe her colleague administering CPR with the aid of prison discipline staff present. On her arrival she had checked for a pulse, but had also been unable to locate one.

E51 This nurse stated that the suggestion was made that a defibrillator might be required. As she attempted to obtain one the ambulance staff arrived and took over. They also were unable to resuscitate the man and so stopped working. It was at this time that she decided to return to the main hospital wing to continue to look after the inpatients and to prepare for prisoners who were due to attend court that day.

E52 Staff present at the scene of the incident advised that the ambulance crew stopped working on the man at approximately 06.05. Records show that ambulance staff left the establishment at 06.21. However, what is now clear from evidence obtained is that at least one of these personnel remained in the establishment to await the arrival of the prison doctor.

E53 The duty SO stated that shortly after the arrival of prison medical staff at the scene he had returned to the Centre and had started to telephone and inform relevant personnel of the incident. One of these persons was the prison doctor, who he requested to attend the establishment.

E54 The doctor arrived at the prison at 07.05 and, on entering the Centre area, was met by a remaining London Ambulance Service person who proceeded to brief him on the situation and of the unsuccessful attempts to resuscitate the man. Having received this briefing, the doctor immediately went to cell E4-01 where he examined the man's body and confirmed that life was in fact extinct.

E55 I have made several attempts to interview the second wing officer with regards to his involvement in the incident. However, this officer has since the date of the man's death been unable to return to work due to the trauma he experienced as a result of these events.

**Establishment: Incident / Post Incident Action**

E56 The duty SO, having attended the scene of the incident and assessed that appropriate staff were present, returned to the Centre and followed the establishment Contingency Orders.

E57 Throughout the incident and post incident period, the officer within the establishment's Command suite / Communications room maintained a log of all relevant events / actions taken in the management of the incident. At 0645hrs, a member of staff was positioned outside of cell E4-01 to preserve the area and to maintain a log of all persons attending the scene.

E58 The incident was reported to the Metropolitan Police and Coroner's Office without delay. Next of kin details were obtained and passed to the Police with a request for them to advise the man’s family of his death.

E59 A hot-debrief of all staff involved in the incident was held at 0853hrs that same day. Appropriate Care Team staff provided support to all members of staff present.

E60 The prison's Management identified a need to provide prisoners on A & E Wing with additional support and, to this end, the provision of services from the prisoner Listener scheme was discussed and made available to all prisoners resident on these wings.

E61 Officers from the Metropolitan Police attended the establishment and E4-01 at 07.47 that same day. These officers later attended the establishment's Boardroom where they were able to speak with the staff involved in the incident. Other police officers were to attend the prison at 11.05 in order to photograph the cell and its contents. Undertakers removed the man’s body from the establishment at 11.57.

**Contact with the man's family**

E62 On entry into the prison on the evening of 24 June 2004, the man had recorded his next of kin as being his sister. However, at this time he did not provide a telephone contact number for her.

E63 Following the discovery of the man and the conclusion of the unsuccessful attempts to revive him, the establishment contacted the Metropolitan Police and requested they contact the man's sister to advise her of his death. They also asked that the Police pass a direct contact telephone number to her with a request that she make contact with the prison's chaplain, who could address any questions that she might have.

E64 By noon, 25 June no contact had been received from his sister. The establishment therefore decided to telephone the man's solicitor and make a further request through those offices for his sister to contact the prison.

E65 It would appear that the man's sister telephoned the chaplain at approximately 14.30hrs on 25 June and it was then that she was told the sad news of the man's death. The inquiry was advised that his sister was understandably upset and had a short conversation with the chaplain.

E66 At approximately 15.00 that same day, the deputy governor of Pentonville, spoke with the husband of the man's sister and explained the circumstances of how the man had come to be in Pentonville and of the assistance and support that the Prison Service could provide the family, if needed.

E67 The deputy governor provided the man's sister with the name of a governor who would act as the prison family liaison officer. It is the understanding of the inquiry that the family liaison officer later made contact with the family to answer their questions and to facilitate a visit to the establishment. In addition, he also attended the Coroner's Court with members of the family to provide support and advice during their meeting with the Coroner.

E68 The inquiry has been informed that the assistance provided by the establishment and in particular the help given by the prison family liaison officer during this period was appreciated by the man's family.

## F Medical Review(s)

F1 In order to gain an assessment of the man's medical treatment during his short period of custody, the inquiry requested the assistance of the Section Head (Substance Misuse) Prison Health Team. He was provided with a copy of the man's Inmate Medical Record and asked to comment on specific questions and of the appropriateness of the man's treatment and location. The inquiry also asked him to identify any issues of concern which he felt would be relevant to the inquiry. For ease of reference, the report is copied in its entirety into the following section:

### Report on Clinical Substance Misuse Management

F2 On coming into prison on the afternoon/evening of 24 June, the man received a healthcare screening interview. This process successfully identified his acute and longer-term health problems (substance withdrawal and deep vein thromboses respectively). The man was correctly referred for a specialist drug and alcohol assessment, which would ordinarily have been conducted on the following day (Friday 25 June). A formal detoxification regime would not be prescribed until this detailed clinical assessment had been completed.

F3 From the medical records I have seen, it appears that the man had substantial alcohol and drug dependence. He had given a consistent summary of his daily substance intake, indicating that he was a regular injector of heroin and crack cocaine. He was also a very heavy drinker, consuming a bottle of whisky plus several cans of high alcohol content lager per day. The dependence on drugs and alcohol is evidenced by the fact that he was seen by doctors on three occasions whilst in police custody. On each examination he was prescribed dihydrocodeine to manage heroin withdrawal symptoms, and diazepam to contain his withdrawal from alcohol and tranquillisers (also known as 'benzodiazepines'). One of the doctors noted that the man was 'Withdrawing + + '.

F4 Following his arrival into Pentonville prison and his reception healthcare screening interview, the man was seen by the prison doctor on the evening of 24 June. The doctor's notes suggest that he found the community medical management of the man's deep vein thromboses had been satisfactory. The doctor also noted that the man had been in prison on three other occasions. The man's vital signs (Blood Pressure 132/78, pulse 83) suggest that he was not in acute drug and alcohol withdrawal at the time of the prison doctor's examination. No clinical drug urinalysis was carried out on the first

evening. In the absence of any drug urinalysis results, the doctor's decision to prescribe 20 mgs of diazepam twice daily alongside the anticonvulsant carbamazepine is wholly understandable.

F5 I will now answer the following questions, which have been formulated to establish the adequacy of the man's clinical management.

**Findings from the medical review**

**Should the man have been in a healthcare unit?**

F6 In view of the man's declared recent drug history I believe that he needed to be located in an area where enhanced supervision was required. This does not mean an in-patient healthcare centre as his deep vein thromboses were not an acute problem, he had no history of serious sedative withdrawal problems such as convulsions or delirium tremens, he had no history of serious mental disorder or of deliberate self harm.

F7 Staff on first night centres have particular awareness of self-harm and suicide, so it was an appropriate location for him. First night centres generally have a higher staff to prisoner ratio than general residential locations, but I understand that there was no enhanced staffing level on the HMP Pentonville first night centre when the man was located there. ***I recommend that this circumstance is reviewed if it is to remain the policy of the prison to accommodate substance-dependent prisoners in the first night centre.***

**Was the medication prescribed for him correct and adequate?**

F8 The man's vital signs (see paragraph 3 above) and the reported observations of staff that he was in 'Good spirits' later that night suggest that the medication prescribed (Diazepam 20 mgs twice daily) was adequate.

F9 As mentioned above, there was no first night qualitative urine drug testing in place for the man. Had there been, it is unlikely that his prescribed care would have varied greatly. I say this because the man had been given both opiates (dihydrocodeine) and benzodiazepines (diazepam and temazepam) in police custody, and these drugs would have yielded positive opiate and benzodiazepine drug tests, irrespective of whatever drugs he had been using prior to his arrest. Thus the test could not have further informed the diagnosis of drug dependence.

**Was the reception screening adequate enough?**

F10 In my opinion it was, although it is good practice to follow up reported drug use with a clinical urine test.

**Were there any irregularities in the patient's medical record (IMR)?**

F11 None. The records are consistent and satisfactory.

**Was the man's treatment compliant with Prison Service Order 3550 (Clinical Services for Substance Misusers)?**

F12 It was. PSO 3550 specifies that detoxification regimes should be preceded by urine drug testing, and both of these events would have been scheduled for the morning of 25 June.

**Should any additional medical instructions have been given regarding the man's supervision on the night of 24/25 June 2004?**

F13 I don't believe so. Considering the facts that the man had no history of deliberate self-harm or of serious psychiatric morbidity, that he had been to prison before and that his offence was very minor, I think that most doctors would have been more concerned about the emergence of problematic sedative withdrawals on the night of the 24/25 June, rather than any risk of suicide.

**Conclusion**

F14 It is my opinion that the clinical management of the man's substance dependence was correct.

F15 The police/court staff observation records were particularly good and all who contributed to these should be commended.

F16 Similarly, all prison staff who came to the man's assistance on the morning of 25 June did all they might and their efforts should be acknowledged.

F17 It is impossible to know to what extent drug withdrawal played a part in the man's death; certainly he had been drinking in sufficient quantity to create a serious temporary depression. His injecting use of crack cocaine would also have made him susceptible to a brief but distinct and sudden lowering of mood. As there is no validated medical treatment for crack withdrawal, the most viable intervention is simply to observe and

support the patient. This I understand was done within the limitations of staffing resources.

F18 I note that the man declared that he smoked 60 cigarettes per day. It is probable that this level of consumption was reduced greatly following arrest. Nicotine withdrawal can increase anxiety; this negative emotion can act in combination with transient but profound drug and alcohol induced depression to make suicide a greater danger.

F19 As stated on page 1, I recommend that the staffing level at the first night centre should be reviewed.

*Section Head: Substance Misuse, Prison Health* *14/09/2004*

**Establishment's Review of Current and Past Inmate Medical Record's**

F20 In addition to the Section Head of the Substance Misuse Team's assessment, the establishment also tasked its own clinical lead nurse to complete a review of the medical documents held for the man. The resultant report confirms no irregularities were discovered within the documentation and makes comment that from the documentation studied all protocols appear to have been followed during the attempted resuscitation of the man on the morning of 25 June 2004.

## G. Level of compliance with authorised procedures

G1 HMP Pentonville was found to hold comprehensive Suicide Prevention and Anti-Bullying Policy documents, which were compliant with current HM Prison Service directives and requirements.

G2 The systems outlined in the Suicide Prevention policy document for the monitoring of F2052SH documentation were found to be good and again fully compliant with the requirements of HM Prison Service directives and requirements.

G3 Contingency Orders were found to be in place within HMP Pentonville which cover incidents of hanging and of the sudden death of prisoners in custody. These also were found to be comprehensive and fully compliant with the requirements of HM Prison Service directives and requirements.

## H. Conclusions

**Reception to HMP Pentonville - 24 June 2004**

H1 Although 'Flagged' on his Police record as having previously self-harmed, the man had been adamant to all whose custody he had been in on 23 / 24 June 2004 that this information had been incorrectly recorded on his records. Certainly from the information available to the inquiry regarding his previous periods of custody, no information could be found that would have indicated that he had ever been considered as a suicide risk. It is also clear that during his return to custody there had not been any concerns raised regarding his risk of self-harm.

H2 The man was received into HMP Pentonville during the early evening of 24 June 2004 and was processed without incident through the prisons reception area. On completion he was taken to the 'First Night Centre' where he was offered, but declined, a telephone call and shower. Instead he was more interested in watching television and the ongoing England / Portugal football match. It is clear to the inquiry that the man was known to many of the staff in the prison and that he had a good relationship with them. They allowed him to be 'last in' to see the doctor so that he could continue to watch the television.

H3 It is also clear, from the evidence given by both the nurse and doctor who examined him that evening, that he was familiar with the procedures of the prison and of the treatment he could expect and was indeed given for his drug addiction. It would appear that he had accepted this and had not become either demanding or agitated during the subsequent medical examination. There was no indication that he had been unhappy with his proposed treatment. This appears to be evident by the way he was still in a jovial mood when seen by staff, after he had left the examination room after being seen by the prison doctor.

H4 It was a failure of the nurse not to complete section 3 of the Cell Risk Assessment Form. However, the inquiry are of the opinion that no information would have been recorded into this section which would have altered the guidance given to the locating officer instructing where or in which type of accommodation the man should be located that evening.

H5 The man was located into a double cell of which he was the only occupant. The officer who located him to this cell stated that he had allocated him to this location because the only other double occupancy cell available already had a prisoner in. He suggested that this prisoner had been mentally ill and was acting in a way that would have prevented the man from gaining a full night sleep. It is considered by the inquiry that this officer carried out this action with the man's best interests at heart. Given his presentation that evening, there was no reason why he should not have been located into a single occupancy cell.

H6 On locating the man into E4-01 the officer recalled that, although initially making a comment that he was on his own, the man had raised no objection or issue with this location. He appeared to have settled well and the officer comments that, when he again checked on him at the evening lock up count, the man gave no reasons for concern. The officer commencing night duty that evening, who also checked on and counted him, echoed this.

H7 The inquiry conclude that the man gave no indication to any person responsible for his custody and care, whether it be Police, Court or Prison staff, that he might be contemplating any act of self-harm. The inquiry are also of the opinion that he was correctly processed into the prison on 24 June and that, given his presentation to all who had contact with him that evening, was correctly and appropriately located into E4-01 a single occupancy cell.

H8 The man had been checked and accounted for when the night patrol officer had first taken control of the First Night Centre (E Wing). Because no concerns had been expressed in regard to him, he was not the subject of any form of enhanced watch. As such, there was no responsibility for the officer to conduct a physical check on him again until the morning count. The only other reason which may have required the officer to attend the man's cell during this period would have been if the man had pushed his cell call light to request assistance from staff.

H9 The inquiry has found no evidence to suggest that the man called for assistance at any time during the night patrol period. Evidence viewed by the inquiry has confirmed that the patrol officer visited E Wing regularly throughout this night period.

**The discovery of the man and action taken**

H10 At 05.35 on 25 June, the night patrol officer in accordance with his duties carried out a roll check of his areas of responsibilities. Starting first on A Wing he then proceeded to E Wing and to cell 4-01. The inquiry has acknowledged that there is no requirement for the night officer to carry out this check in any prescribed order. It is a matter of personal choice, so long as all cells are checked.

H11 On opening the cell door observation panel the officer saw the man suspended by a ligature. He raised the alarm and then using the cell key from his sealed pouch, entered the cell and immediately cut the ligature from his neck, laying him down onto the floor. The inquiry is of the opinion that the night patrol officer acted swiftly on this discovery and carried out his duties fully and correctly and in compliance with current Prison Service Orders.

H12 The response to the emergency call was appropriate and fast. On the arrival of other officers attempts were made to administer CPR to the man. It is accepted by the inquiry that despite the initial efforts made by these staff, the start of this process was slightly delayed by the inability to successfully insert a one way valve / mouth-cover to safely commence mouth to mouth breaths.

H13 Medical staff and resuscitation equipment in the form of the emergency response bag(s) arrived at the scene extremely quickly. This equipment was deployed appropriately and again without delay. The inquiry is of the opinion that all staff present, both nurses and officers, worked extremely hard in their attempts to revive the man that morning. Although there are some slight differences in the descriptions given by staff of the events, it is considered by the inquiry that given the trauma experienced by those present, this is only to be expected and is accepted as such.

H14 It is of concern to the inquiry team that having only two nursing staff on duty that night, both of whom attended the scene, the forty-three bedded Healthcare Unit would appear to have been left unsupervised for the period that both nurses were in attendance. It is noted that one of these nursing staff stated they had to return to staff the unit. Whilst this issue is highlighted, the inquiry wishes to make it clear that it is of the opinion that the absence of this second nurse from the scene in no way lessened the standard of medical intervention being given to the man.

H15 The duty SO correctly followed emergency procedures in requesting the attendance of an ambulance and then ensured that officers were available to allow entry to the establishment and escort these personnel to the man. The subsequent arrival of these personnel to the prison was again extremely fast, taking only some five minutes from the time of the call being made from the Communications room.

H16 On the arrival of London Ambulance staff at the scene, control of the medical intervention was handed over to them. This is in line with present protocols / procedures and is considered to be correct. Despite their continued attempts to revive the man they were unable to do so and at 06.06 made the decision to stop CPR.

H17 It is not clear from the documentation how many London Ambulance Service staff remained in the establishment, but at least one person did to await the arrival of the prison's doctor who had earlier been requested to attend the prison. On the prison doctor’s arrival at the prison, he received a briefing from the member of the London Ambulance Service and attended the cell where he was able to confirm that the man had died.

H18 Having assessed the evidence given by the duty nurse and the reported comments made by the ambulance crew, it is likely that at the time of discovery of the man he had been dead for some time. It is to the credit of all staff who participated in the administration of CPR that morning that despite the evident signs that death had already occurred, they still made valiant attempts to revive the man.

**Action taken by the establishment management**

H19 The duty SO attended the scene and, having assessed the situation, proceeded to the Centre of the prison to initiate Establishment Contingency Orders. Whilst this was correct and in accordance with instructions, he failed to identify an officer to take charge at the scene (Bronze Commander). A further omission was made when no individual was appointed to be the scene Log Keeper. Whilst it is accepted that the resources available to the senior officer were extremely limited, these elements would have been considered essential if it had become a Police criminal investigation and the cell a scene of crime. The log being made within the Communications room for the incident would not have had any evidential value in relation to the scene.

H20 On completion of the efforts made by all staff to revive the man, cell E4-01 was sealed and, at 06.45, a member of staff was posted to commence a log and prevent unauthorised entry to the scene. The resultant Log provided was extremely helpful to the inquiry and fulfils all the requirements needed for the preservation of evidence. It is refreshing that prison management initiated this action, as this is often a requirement that establishments fail to carry out.

H21 The organisation of a hot-debrief, and provision of staff care and welfare for all staff involved in finding and trying to help the man, was quickly arranged and implemented. The provision of both is in line with the requirements of the management of a serious incident. It is encouraging that all staff reported that they had received good management support and that this had been ongoing. Appropriate support was also initiated for prisoners subject to F2052SH monitoring throughout the prison and those who felt that they had been affected by the incident.

H22 All staff remained on duty beyond their shift timings and co-operated fully with management and the attending police officers. The inquiry is of the opinion that both the incident itself, and the management of the actions that followed, were carried out correctly and in accordance with current instructions.

**Contact with the man's family**

H23 The request for Police to make contact with the man's next of kin in the absence of an available telephone number is considered to be appropriate and correct. A question posed and not evidenced in the incident documentation is what, if any, further contact was made with the Police to identify what actions they had taken in response to this request. Having stated this, it is commendable that having had no contact from the man's family, management at HMP Pentonville took the initiative to make contact through the man's solicitors office. It is considered that the establishment made a genuine effort to make contact with the man's family at the earliest possible opportunity and to advise them of his death.

H24 The provision of a named family liaison officer at governor level was appropriate and helpful. The enquiry has been impressed by the reported actions of this governor and the extent to which he has gone to provide aid and support to the man's family.

H25 The inquiry are of the opinion that HMP Pentonville and its management carried out its duties and obligations fully in both contact and provision of support to the man's next of kin and family.

**Medical Reviews**

H26 From the assessment provided by the section head of the substance misuse team and lead nurse and the observations made by the inquiry itself, it is felt that the man received appropriate medical treatment during his brief period of custody at HMP Pentonville.

**Other Issues**

H27 It is has been brought to the attention of the inquiry that, following the man's death, at least two members of staff involved took sick leave which they attributed to the stress and trauma caused them by the events of the incident.

## I. Recommendations

I.1 The governor should commission a review of the night staffing levels of A & E Wing to identify if there is a need for additional supervision within the First Night Centre given that newly received prisoners identified as having a drug dependency are to be located there.

I.2 The governor should commission a review into the systems employed by the Health Screening Nurse to ensure that in future Section 3 of the Cell Risk Assessment Form is completed and that Prescription Charts for newly received prisoners to the establishment are not misplaced or lost.

I.3 The prison doctor supplied protocols for the treatment of prisoners received into the establishment with a drug dependency to the inquiry. These protocols were dated August 1998. The inquiry recommends that the governor commission a medical working group to review and confirm the use of these protocols. Upon completion the group should ensure that copies are held in all relevant working areas of the prison.

I.4 Instructions for the deployment of emergency staff during the working day are present within the establishment. It is of concern that the same does not appear to apply during the night period. The governor should commission an immediate review of the alarm response instructions for night periods. A formal instruction should be issued which should allow key personnel to attend the scene of any serious incident, whilst providing their own areas of responsibility suitable supervision. (Example: In the event of a level 1 emergency call, R Wing OSG will patrol hospital and R Wing for duration of incident. etc).

I.5 The governor should ensure that his night managers are reminded of the importance of appointing a Bronze Commander to manage the incident scene, when they themselves need to leave the area and of the need to task the post of Incident Log Keeper to an individual positioned at the scene.

## J Examples of Good Practice

J1 It is considered an example of good practice that all night patrol staff on commencing duty at HMP Pentonville are issued with a utility belt containing a cut down tool to enable them to remove ligatures and equipment to commence CPR. It is felt that this practice should be shared with other establishments within the Prison Service Estate with a view to standardising this procedure throughout the service.

J2 The governor should recognise the actions of all staff involved in the delivery of CPR to the man on the morning of 25 June 2004. Despite the obvious signs that the man had already died, these staff initiated CPR during what must have been an extremely distressing period.

J3 The governor should recognise the actions of governor appointed as family liaison officer in his contact with the man's family, in particular visiting the Coroner's court with them.