

**Investigation into the death in custody of
a man at HMP Pentonville on 10 October 2004**

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

July 2005

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This is the report of an investigation into the circumstances surrounding the death of a man who was found hanged in his cell at HMP Pentonville on 10 October 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 a Senior Investigation Officer (SIO) from the Prison Service's London Area Office. An independent clinical review was conducted by Islington Primary Care Trust. I am grateful to all members of the team for their work.

A member of staff from my office liaised with the SIO during this investigation. I have structured this report so that the SIO's investigation can be separately identified.

Two members of my staff visited the man's sister. I know that they offered their sympathy and condolences, but I would like to take this opportunity to add my own sincere condolences to the man's sister and friends.

I should record here my thanks to the governing Governor and his staff for the help the investigators received during the investigation. All staff co-operated fully and readily with the inquiry.

It appears that the man took his own life, although he had given no indications that he was considering such a course of action. What was in his mind can only be guessed at, but it is likely his death followed shortly after he had learned how long he would have to serve having been returned to prison for breach of his licence conditions.

There is no doubt that he was in breach of those conditions. However, his act of sending a very brief letter to his former partner (the mother of his victim), apparently ending their relationship for good, was scarcely heinous. It is not comforting that the rigorous enforcement of licence conditions may have had such a tragic consequence.

**STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN**

July 2005

SUMMARY

The man had been released from prison in July 2004 having served a period of nine months in custody. His original sentence had been one of 18 months, with a further four years on extended licence. In October 2004, the man breached one of his licence conditions and that led to him being re-arrested in the early hours of Wednesday 6 October and taken into Pentonville later that same day.

There is reason to believe that the man was unaware of what he had done to trigger his re-arrest, and staff in Pentonville were certainly unaware of the reasons, until receipt of information that arrived after the man's death.

When received at Pentonville, the man was taken through a first reception health screen by a nurse with a mental health qualification. The nurse identified no concerns that the man might be at risk of self-harm or suicide. The man was also seen by a doctor who recorded his mental condition as stable. The man was initially placed in a single cell in the prison's first night centre.

On 7 October, the man declined the offer of an induction interview. He did not feel he needed this, and it is not unusual for those who had been in prison before to decline an induction interview.

On Friday 8 October, the man was moved from the first night centre to a double cell in A-Wing. The man shared that cell with another prisoner for one night, but the cellmate was moved to another part of the prison on the morning of 9 October.

When staff in one of Pentonville's administration units carried out the man's sentence recalculation, it resulted in a conditional release date of 19 November 2008. A confirmation slip with this information was sent to the man through the prison's internal postal system. It has not proved possible to trace this confirmation slip, but the indications are that the man might well have received it on Saturday 9 October. No other information accompanied the sentence confirmation slip. Information about the reasons for the man's recall to prison and about the licence recall appeal process were included in a 'representations pack', issued by the Prison Service's Early Release and Recall Section, which arrived in Pentonville on 11 October, the day after the man died.

When prisoners were unlocked on the morning of Sunday 10 October, the man was found hanging. Descriptions of his condition when found suggest that he had been dead for some time.

Although this investigation has not revealed anything to indicate that staff should have recognised that the man was at possible risk of self-harm, a

number of serious omissions have been identified in connection with how staff carried out their roles and responsibilities on the night of 9 October and the morning of 10 October. For a substantial period of the night, the night officer failed to carry out his landing patrols in accordance with instructions. Nor did the night officer carry out his morning role count in accordance with instructions. At the time he said he checked the man – probably some time between 5.45am and 6.30am – the man was almost certainly dead, yet the night officer saw nothing untoward.

When the night officer was relieved by a day officer at 6.45am, the night officer said that he had conducted a roll check, that everything was in order and that it was not necessary for the day officer to conduct her own roll check. Even though the day officer had not long been trained, and was aware that she was required to carry out a roll check of her own, she did not make such a check.

It was not until 9.30am, as prisoners were being unlocked to collect medication, that staff looked through the man's cell door hatch and saw him hanging. The staff panicked. The first officer, on seeing the man, called a second officer. He looked through the hatch and called a third officer. The third officer looked through the hatch and, realising that help was needed, ran to the wing office to make an alarm call. Medical staff and several senior officers seem to have responded very quickly to the alarm. In the meantime, the staff who had found the man remained outside his cell and only unlocked the cell door as assistance arrived. When the cell was finally entered, there was a further delay in cutting the ligature from the man's neck while staff obtained a suitable pair of scissors – the first pair, described by one member of staff as 'nail scissors', being unsuited to the task.

The likelihood in this case is that the man was already dead at the time of the night officer's supposed morning check at between 5.45am and 6.30am. Consequently, the delay in the man being discovered and then the added delay in the staff response are unlikely to have had an effect on the outcome. However, in other circumstances, such delays could have been of paramount importance resulting in a life being needlessly lost. This is a matter of great concern.

It is also of concern that licence recall prisoners are notified of their sentence recalculation by being sent a slip of paper via the internal postal system. Information about the sentence appeals process is not included with the notification slip. The man's sentence recalculation gave a release date of 19 November 2008. This might well have been a surprise to him, and possibly more difficult to deal with if, as seems likely, he received the information on Saturday when prison staffing is at a reduced level.

In addition to identifying omissions on the part of individuals, this investigation has also identified inconsistencies in Pentonville's night orders and staff understanding and compliance with those orders. This report makes recommendations which include a review of the night orders, the need for staff training, and a change in the manner in which licence recall prisoners are informed of their sentence recalculation. This report also recommends that the Prison Service consider undertaking disciplinary investigations into the actions of two members of staff – the night patrol officer and the morning relief officer.

Senior Investigation Officer's Report

Investigation Process and Methodology

On 2 November 2004, accompanied by a member of staff from the Ombudsman's office, I attended HMP Pentonville and met with members of the management team. We received a full and in-depth briefing as to the actions taken by the prison in regard to the incident, post-incident management, and contacts they had made with the man's family and outside agencies such as the Coroner's Office and police.

I took possession of a large quantity of documentation relating to the man's period in prison custody and was able to study these at length. I later provided the prison's liaison officer, with a list of additional documentation which he obtained for me without delay.

I took the opportunity during the visit to plan the investigation strategy, discuss investigation parameters and agree individual responsibilities. I visited the scene of the incident and was able to gain a briefing as to A-Wing's function and regime. I was later able to speak with staff and prisoners located on the wing to gauge if there were any underlying issues relevant to the investigation.

Whilst at the prison, the Ombudsman's officer and I met with representatives from both the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB) to explain the inquiry process and how we intended to conduct the investigation. We also explained the process of disclosure of the resultant Ombudsman's report and extended an open invitation to both POA and IMB to meet with us at any time to discuss issues of concern should they arise.

During the early stages of the inquiry, I contacted the police officer responsible for investigating the incident on behalf of the Metropolitan Police and advised him of the Ombudsman's investigation and the areas that it would cover. I offered my co-operation and to share any information which might be of relevance to his inquiry. The liaison established between police and the inquiry team proved to be very effective and I hope beneficial to both.

I studied all documentation provided by the establishment and identified the persons whom I felt would need to interview. During the inquiry, I have formally interviewed 19 persons and have spoken to a further seven persons with case notes taken. I have also spoken with a number of other people within the establishment. However, I considered that they were unable to contribute information of an evidential value to this investigation.

I would like to thank the management and staff at Pentonville for the co-operation they provided during the course of the investigation. Additional thanks are extended to the prison's liaison officer, a task he fulfilled to an extremely high standard.

HMP Pentonville

Pentonville was built over 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.

The prison's regime includes education with full time/part time and evening classes, workshops, and training courses. Offending behaviour courses, such as 'enhanced thinking skills' are available. The establishment also provides special features such as a dyslexia project, an NVQ painting shop and community work.

Pentonville has a 24-hour healthcare service staffed by a full time senior medical officer, supporting clinical staff, and nurses. Pentonville has a hospital wing with 43 in-patient beds.

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

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

The prison has links with outside agencies. For instance, the Probation Service sits on the drug strategy group, the prison has a group to represent prisoners' families, and the Rehabilitation of Addicted Prisoners Trust provides drug rehabilitation programmes. Pentonville is represented on the Camden and Islington Drug Action Team.

Pentonville accepts all suitable prisoners from courts within its catchment area of north London. It currently has a certified normal accommodation of 897 and an operational capacity of 1,205. On the night of 9 October 2004, the prison held some 1,177 prisoners.

In the period immediately preceding the death of the man, the establishment opened a 'First Night Centre' in E-Wing (attached to the end of A-Wing). The purpose of the unit is to house all newly received prisoners into the establishment. Prisoners usually remain in this unit overnight or until processed and then move on to other residential wings, dependent upon individual needs and categorisation.

The First Night Centre is staffed by officers 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 their arrival in the prison.

Sequence of Events – Overview

Time Line

The following is a list of the significant events during the man's period in custody, the discovery of him hanging in his cell, and the events following that discovery. These events will be covered in greater detail in the relevant sections of the report.

8 May 2003	Sentenced to 18-months imprisonment
5 July 2004	Released on Extended Licence
1 October	Reported breach of Licence
5 October	Licence revoked
6 October	
2.30am	Police arrest and assess the man 'No Known risk'
1.40pm	Received into HMP Pentonville
7.16pm	Located to E Wing First Night Centre
8 October	
2.58pm	Located to A-Wing The man's sentence calculated by Inmate Administration office and sentence advice notice posted in internal post system
9 October	The man's cellmate relocated because of security status
10 October	
6am	A-Wing Night Patrol Officer conducted count of wing with nothing to report
6.45am	Night Patrol Officer having been relieved goes off duty
7.30am	A-Wing signed as all correct by Officer starting day shift
9.30am	Staff unlock cell A5-14 and discover the man suspended
9.35am	Alarm raised and medical staff attend scene
9.40am	The man is pronounced dead by doctor
9.45hrs	Establishment inform Metropolitan Police of incident
9.50am	Ambulance and Police attend the prison
10am	Staff attempted to obtain next-of-kin telephone but failed
2.14pm	Coroner's Officer arrives at scene
2.18pm	The man's body removed from Pentonville.

The above list is by no means a comprehensive record of all the events and should not be considered as such. It is provided purely as a guide.

Licence Recall and Sentence Recalculation

An administrator from Pentonville's Inmate Administration office explained that, under the provisions of the Criminal Justice Act 1998, the courts have powers to extend licence periods in the case of sexual offences or extremely violent offences. In the man's case, the custodial term of his sentence was 18-months, but with a four-year extension of the licence. As in the case of any person sentenced to 18 months, the man actually served nine months in custody, but he remained on licence to an extended licence date of 19 November 2008.

The administrator said that the revocation of licence notice from the Early Release and Recall Section, in conjunction with the previous sentence calculation, are used to calculate the new release date. A two-part computer printout is produced showing the release date. One part is for the prisoner and is delivered through the prison's internal post system. The man's sentence calculation was completed on 8 October showing the following information:

Conditional Release Date: 19 November 2008

Home Detention Curfew date: 8 July 2008

Sentence/Licence Expiry Date: 5 April 2009

The earliest date of the man's release from custody was therefore shown as 19 November 2008.

An appeal process is built into the recall procedure allowing the prisoner to put their representations to the Parole Board. The process is explained in a 'representations pack', which also explains the reason for the recall being activated. Until receipt of the pack, a prisoner would not necessarily know about the appeals procedure, or even the specific reason for recall. There can sometimes be delays of two or more weeks for receipt of these packs, although the man's pack was received at Pentonville on 11 October.

The administrator could not confirm when the notification slip would have been delivered to the man, and it has not proved possible to locate this form. The administrator suspected that the form might have been delivered on Saturday 9 October. She had gone into Pentonville on Sunday 10 October and heard that there had been a death in custody of a prisoner on an extended licence who had received a notification slip on Saturday with a release date that he was not expecting.

The procedures and instructions for dealing with Licence Recall prisoners are governed by Prison Service Order (PSO) 2300 and Prison Service Instruction (PSI) 6000. These state that within three working days of notification to the Early Release and Recall Section at Prison Service Headquarters of a recall prisoner's return to prison, he/she should receive a pack explaining reasons for recall and the appeal procedure.

Reception to Pentonville and Events Leading up to 10 October

The man was received into Pentonville from police custody at approximately 1.40pm on Wednesday 6 October. On arrival at Pentonville, the man was taken through a standard prison reception process.

The man was interviewed by a reception officer for completion of a Cell Sharing Risk Assessment. This was to assess the man's suitability for sharing accommodation with other prisoners and/or to identify any individual needs or factors relevant to the type of accommodation allocated him. At interview, the reception officer described the purpose of the risk assessment as: *'To check the inmate's suitability ... to share a cell, [whether he has] suicidal tendencies, if he's got any problems, if he's on medication'*. The reception officer said that, had he noticed any concerns of this nature, he would have initiated the F2052SH procedure. However, he did not observe any such signs with the man.

The reception officer's impression of the man that night was that: *'He seemed a bit withdrawn. He seemed a bit confused. When I say withdrawn ... he didn't portray any suicidal tendencies or he didn't seem very disturbed or anything like that, he just seemed a bit confused about being recalled to prison. I asked him why he had been recalled and he shrugged his shoulders. I asked when he'd been in prison before did he have any problems with depression and ... he says not. I asked him is he feeling okay, he says yeh ... I made a note for the doctor and there was nothing out of the ordinary.'*

The reception officer confirmed that the man was issued with a reception pack and given a pin number to allow him to make a telephone call. The reception officer asked the man whether he wished to be placed on rule 45 due to his original offence, but the man rejected that option (rule 45 provides for the segregation of prisoners who might be vulnerable or who might pose a threat to prison discipline).

The man underwent a First Reception Health Screen, conducted by a reception nurse who is a registered general nurse and registered mental health nurse. At interview, the reception nurse said: *'The man didn't present any sort of debilitating psychiatric problem, he has not presented any feelings of being agitated, depressed, suicidal, he appears to be calm, quite settled and all that he wanted was assistance with his irritable bowel syndrome ... I referred him to the doctor so if there was any issue relating to this man being distressed, disturbed, unstable, low mood, any form of risk it would have been taken up.'*

The reception nurse confirmed that there was no indication of any form of risk or past self harm incidents recorded on the man's Prison Escort Record (PER) or other accompanying documentation. The reception

nurse said that he had not observed anything to cause him concern. If any issues of concern had been identified, a F2052SH (self-harm at risk form) document would have been opened. There was no need for this in the man's case.

The man also saw a reception doctor, during which the reception nurse remained present. The doctor recorded the man's mental condition as stable. The doctor prescribed the man a once only dose of Zopiclone, to help him sleep. After he had seen the reception doctor, the man was taken by the reception officer to the First Night Centre.

On 7 October, an induction officer saw the man and gave him an information pack containing a reception letter, a postage-free letter and a guide to prison routines and regimes. The induction officer invited the man to attend a prison induction, comprising a one-to-one interview and group presentation. The man declined the offer, however, saying that he was already aware of what would be said. When interviewed for this investigation, the induction officer said that it was quite common for prisoners to refuse to attend induction if they had been in prison before.

In accordance with normal procedures, the man remained in the First Night Centre until the afternoon of 8 October when he was relocated to A-Wing to help make space for new prisoners to be received into the prison that day. The man was allocated to cell A5-14 on A-Wing. This was a double occupancy cell situated on the top landing. Between 6.30pm and 7.30pm that evening, a second prisoner was located into the cell with the man.

The man's cellmate confirmed that he shared the cell with the man for just one night, the night of 8/9 October. They had spoken about their sentences. The man said that he was a licence recall prisoner, but did not talk about his sentence or his offences. The man mentioned his probation officer and that he had contacted him in the recent past. The cellmate lent the man some tobacco. The cellmate believed that he eventually went to sleep about midnight. On the morning of Saturday 9 October, the cellmate was taken to the segregation unit, as he was facing possible re-classification to a category A prisoner. That was the last time that the cellmate saw the man. The cellmate said that he was shocked to learn subsequently that the man had taken his life.

No information was recorded in the man's records in respect of any interaction between him and staff, or with other prisoners, during the day, evening and night of Saturday 9 October. The A-Wing roll was signed at 6pm. As the man was not employed as a cleaner, it is probable that he would have been locked in his cell at some time prior to the 6pm roll being taken. He would not have been allowed out of his cell for the remainder of that night.

An undated letter from the man to his sister, postmarked 11 October, asked her to send him some money and, perhaps more importantly, comments that he was still unaware of why he had been recalled to prison. This letter must have been sent between 6 and 9 October for it to have a postmark of 11 October.

The night officer on night duty in A and E Wings for 9/10 October had worked in Pentonville for over 12 years. During this time he had completed many night duty shifts. It was not the practice for the Night Orderly Officer to brief the night patrol staff at the beginning of a period of duty, but the night officer did not consider that he needed a briefing due to his level of experience. In the case of new officers, one of the more senior officers would go round with them to show them how to carry out their role.

On 9 October, the night officer arrived at the prison at about 7.40pm. This was around one hour earlier than the normal start time for a night shift, but he had agreed to do this to allow the day duty officer to leave early.

The night officer counted the prisoners in A and E Wings, and this took approximately 45 minutes. This was the final count required of the Night Patrol Officers; the next count would not be until 5.45am the following morning. It was only during formal counts that staff were required to look into the cells during the night, apart from in the case of increased observations for prisoners on self-harm monitoring. The man was not subject to this increased level of observation and the night officer had no interaction with him that night.

The night officer said at interview that practice at the prison was just to 'sight' prisoners during the evening roll count. The night officer was asked about Pentonville's orders for night patrol officers, suggesting that the officer be required to get a response from prisoners. The night officer said that he had never seen those orders.

After completing the count, the night officer said that his duties were to then answer all the emergency light bells and to 'peg out'. ('Peg out' refers to a computerised monitoring system requiring staff to press buttons located on patrol routes within the wings. The system records time and location of buttons pressed and therefore confirms that patrols are being carried out).

The night officer was asked at interview about discrepancies in the night report sheets which show that between 1.55am and 4.58am on the night of the 9/10 October, no pegging had been completed on either A or E Wings. Furthermore, there was no explanation in the night report sheet to account for these omissions. The night officer said: *'There was quite a few incidents that night and I was on my own on A and E Wing and*

usually I'll have someone else in up there with me but that night we didn't have the staff. So I just had so much to do, we were moving [people] from B and G Wing over to E Wing which was my wing because there was flooding and Listeners backwards and forwards as well and an hour of that would have been my lunch hour as well and my tea break.'

On the night of 9/10 October, only one of the cells next to the man's was occupied (A5-15). Neither of the prisoners occupying that cell heard anything untoward during the night.

At 5.45am on 10 October, the night officer started his morning count. This required him to make a visual observation of every prisoner. Although it had been dark at the time of the check, the night officer said that he did not need to use a torch. The sun was rising and there was enough light to see. He said that he did not recall the man's cell in particular, and nothing occurred to cause him to remember it. The night officer stated that he had not seen the man hanging at the window. Nor had he seen any ligature.

The night officer said his count had taken 35 to 45 minutes to complete and he then signed his night report sheet, timing the form at 6am. He said that all staff normally recorded 6am on the sheets even though the count was not necessarily carried out at precisely that time.

When the day officer came on duty that morning, the night officer advised her that she did not need to count the prisoners because he had already done so. The night officer was present when the day officer signed to confirm the wing numbers and to take over the area. The night officer left the prison at 6.45am.

The Discovery of the man's Death

At interview, the day officer said that she had previously been an Officer Support Grade within the prison's canteen, and had been employed as a Prison Officer since June 2004. She had completed her officer training course and was serving her probationary period. In training she had been told that it was a requirement, on taking over a wing from another officer that the on-coming officer should count the prisoners and then sign to confirm that all were present. She understood that the purpose of that count was to check that all prisoners were present and that all were well.

The day officer arrived at the prison at about 6.45am on the morning of 10 October. She had not counted the prisoners on taking over from the night officer because she trusted him, as an experienced officer, when he said that he had completed a count and it was not necessary for her to make her own count. Since starting work on A-Wing, the day officer had found that the practice was for day staff to trust the statement made by the night officer that all was fine and not to carry out their own check.

At about 9.30am, the day officer, working with colleagues, began to unlock cells for prisoners to collect medication. When the day officer opened the observation flap on the man's door she saw him by the window and realised he was hanging. She could see the ligature. She called to a second day officer who was close by. The second day officer looked through the observation flap and then called to the third day officer to help and to raise the alarm. The day officer played no further part in dealing with the incident, instead began to lock prisoners back into their cells.

The second day officer said that the day officer was at the cell ahead of him when she called his name. The second day officer opened the observation flap of the man's cell door and saw him hanging from a ligature at the window. The second day officer was certain that the man was dead. The second day officer called to the third day officer. Although the second day officer was carrying a radio, the third day officer went to the wing office to call for assistance from there.

The second day officer acknowledged that he panicked. He did not enter the man's cell, but waited for several minutes until other staff arrived. When support arrived, the second day officer unlocked the man's cell door and then rushed to the wing office to collect scissors and a chair to help free the man from the ligature. The second day officer said that staff do not carry anti-ligature knives or scissors as part of their standard equipment.

The third day officer confirmed what the other day officers had stated. He was called by the second day officer and saw that a prisoner was

hanging with a bed sheet around his neck that appeared to be tied to the window. The prisoner seemed to be lifeless. The third day officer ran to the wing office to telephone the emergency prison number, as this would get the quickest response. Help arrived within a few minutes.

After making the call, the third day officer concentrated on ensuring that prisoners were locked back into their cells and the landing kept clear for the medical staff. The third day officer said that his first thought was to obtain medical assistance, rather than to enter the man's cell with a view to giving medical assistance himself.

The fourth day officer was the first member of staff to arrive on the scene in response to the alarm call. The fourth day officer looked through the cell door observation flap and saw the man hanging by a ligature that was clearly visible. The second day officer unlocked the cell door. As the fourth day officer entered the cell, senior staff arrived, took charge of the scene, and instructed the fourth day officer to help clear the landing.

Two senior officers were together when they heard the alarm call from A5 landing. They responded immediately and entered the man's cell. While the first senior officer took over the wing telling prisoners to get behind their doors, the second the second senior officer cut the ligature from the man, assisted by the principal officer. The principal officer said that he could see the ligature attached to the window as he entered the cell. There was some initial difficulty in cutting the ligature because the first scissors brought were 'tiny nail scissors'. Someone then brought the correct scissors and the ligature was cut through.

A staff nurse arrived at that moment and assisted in lying the man onto the floor. The staff nurse said that this had been quite difficult, as rigor mortis had set in. As soon as the man had been laid down, the duty doctor arrived. The duty doctor examined the man and recorded that his face was cyanosed (blue in colour), that his neck and body were stiff and cold, that he had no pulse or heart sounds, and that he was not breathing. The duty doctor pronounced the man to be dead. This record was timed at 9.40am.

After the man's death

The governor in charge of the prison that day opened the Command Suite and followed the establishment's Contingency Orders for dealing with deaths in custody.

The man's cell was sealed and evidence preservation procedures were initiated. An activity log was opened without delay.

All relevant outside agencies and departments: the police, Coroner, Prison Service National Operations Unit, Samaritans and IMB, were contacted.

At 2pm, the governor in charge held a hot debrief for all staff involved in the incident. He later held a second debrief in the prison chapel to advise all establishment staff of the incident and of what action had been taken. Staff involved were requested to write statements and incident reports about their actions.

On call support staff were called in to Pentonville to provide ongoing assistance to both staff and prisoners who might have been affected by the events.

Initial attempts to contact the man's family were unsuccessful. Contact was eventually made, later on 10 October by the governor in charge. However, he discovered that the family had already been visited by the police and told of the man's death.

Staff from Pentonville maintained close contact with the man's sister thereafter and she, accompanied by her family, visited the prison on 12 October. The man's sister met the prison's governing Governor and was shown the cell in which her brother had died. She was accompanied to the cell by a Church of England chaplain who said a prayer for the man.

At the request of the family, the chaplain conducted the man's funeral service on 20 October. The governor in charge also attended the service.

Further contact with the family was made to answer questions about the circumstances surrounding the man's death and to assist with funeral expenditure.

Night Procedure Guidance /Local Operating Practice guidance and actual practice at weekends.

I spoke with a senior officer and a principal officer about actual operating practices compared to Pentonville's procedural guidance.

I was told that practice for many years has been for staff to disregard the instruction in the night patrol officer's job description that they should obtain a response from prisoners when carrying out the morning count. The principal officer said that waking 1200 prisoners at 5am or 6am was not practical and would cause disruption.

Day staff officially start work at 8am, but are allowed to take over from the night staff as early as they want – day staff will often arrive early to relieve the night staff, who reciprocate by arriving early the following evening to relieve the day staff. Although the night guidance orders state that a roll call should be carried out by day staff at 7.30am, this is not feasible because, technically, no day staff are on duty at that time. In practice, the roll call is carried out over a period as day staff arrive.

Again, practice for many years has been for the night staff to leave the prison once relieved by the day staff – night staff are not held back while the day staff carry out their count. This practice accorded with a Governor's Order issued on 1 May 2003, although the local operating practice instruction issued in February 2004 made it clear that night staff should not leave the prison until day staff had completed their count.

I found the normal practice at weekends was for one night patrol officer to cover both A and E Wings, although Pentonville's local operating practice instructions state that one officer should be deployed on A-Wing and a second officer deployed onto E-Wing.

Findings

Discharge from HMP Littlehey

On discharge from Littlehey in July 2004, the man was given a copy of the licence showing the conditions that had been imposed. While in custody, and at the time of discharge, he would have had the opportunity to seek clarification of these conditions and the extended licence procedure.

The letter that the man wrote to his ex-partner amounted to some three lines of a non-threatening nature. It could even be viewed as a final farewell letter, when it ends in 'Goodbye'.

It does not appear that the man was approached by his Supervising Officer and asked for an explanation for his actions. However, regardless of its contents, sending the letter constituted a breach in the man's licence conditions and as such was grounds to revoke his licence. Once the man's licence had been revoked, the degree of the breach would be open to scrutiny at any subsequent appeal hearing.

The nature of the breach was not recorded on the order to revoke the licence. This led to confusion, possibly for the man, but certainly for the police responsible for carrying out the arrest and also for Pentonville upon receiving the man.

Wednesday 6 October

The man was received into Pentonville on Wednesday 6 October. He received a health-screening interview during which no issues of concern were identified with regard to his mental health by any of the personnel who saw him.

The man had a Cell Sharing Risk Assessment and was confirmed as presenting no reason why he should not be located with other prisoners. Due to the nature of his original offence, the man was given the opportunity to request removal from normal location, but he declined this offer.

I am of the opinion that the prison reception process was conducted properly.

Thursday 7 October

I am satisfied that the man was offered a full prisoner induction package and interview, but chose not to become involved. Had he engaged in the process, this would have provided him a further opportunity to raise any concerns he might have had regarding his return to custody, the licence revocation procedure, and appeals process.

Friday 8 October

In accordance with Pentonville's induction procedures, the man was relocated to A-Wing on the afternoon of Friday 8 October to facilitate space for new receptions to the prison.

The man was located to a double occupancy cell on A5 landing and was joined by a second prisoner that evening. There is no evidence that there were any problems between the two individuals. Indeed, it seems the two spoke at length during the period that followed, during which time the man told his cellmate that he was unaware of why he had been returned to prison. (It might of course be that he did not wish to mention the nature of his original offence.)

Staff in Pentonville's Inmate Administration office calculated the man's release and sentence expiry dates based on information received from Littlehey. A notification form showing these dates was despatched to the man through the prison's internal post system.

The man's reception pack had still not arrived at this point, so staff at Pentonville were probably unaware why he had been recalled to custody.

No information explaining the licence recall process is given on a prisoner's return to custody, nor when the prisoner is issued his new sentence calculation dates. This information is supplied in the 'representations pack', but there can often be a substantial delay in receipt of this pack.

Saturday 9 October

The man's cellmate was relocated during the Saturday morning as a result of his potential heightened security status. The man remained in the cell on his own. The man presented with no self-harm or mental health concerns, and the fact that he remained in the cell on his own for the rest of that day was normal practice.

Although I have been unable to verify that the man received his sentence calculation notification, I am confident that he would have received this sometime during either the morning or afternoon of Saturday 9 October. The method of delivery of this information could be viewed as being somewhat insensitive or impersonal. However, given the high volume of prisoner movements on and off of the wing and the officer/prisoner ratio, it is understandable why the current procedure is followed.

I have found no evidence that the man raised any concerns with staff regarding his sentence calculation.

Night Procedure Guidance Notes and Operating Practices

I have great concerns that establishment orders are in place, which:

- appear not to be read or complied with by managers and staff alike.
- set out a regulated and documented handover system, but which again are not followed by managers and staff who, at best, follow a fragmented version of the system.
- do not take account of shift attendance times at weekends – night duty staff finish at 7.45am, day staff commence their shifts at 8am.
- are unrealistic of what is required of an officer – does the Governor really want staff to wake prisoners at 6.15am on Saturday and Sunday? Staff are clearly unsure as to what is required.

I am further concerned that there appears to be no formal briefing by night managers when staff commence their shift and that no record is kept to confirm that staff have read and understood their orders.

I am also concerned that it would appear that, instead of providing staff with these written orders, the routines are simply passed from one officer to another. The likelihood that bad habits or omissions in duty will also be passed on at these times is apparent.

Night of 9/10 October

Pentonville's night orders state that there should be one patrol officer for A-Wing and one patrol officer for E-Wing. In practice, this has never been the case and only one officer is normally supplied to patrol both wings. I am advised that, when the First Night Centre was created on E-Wing, this new function was not re-profiled to identify if any extra staffing was needed for night duty.

The night officer, the patrol officer on duty in A-Wing on the night of 9/10 October, said that he had been busy that night and that was why there was a gap in pegging of some three hours between 1.55am and 4.58am. The night officer's statement is not reflected in his night patrol report that only records four, timed, Night Orderly Officer visits and a non-timed entry about two prisoners being moved between wings due to flooding in a cell. The night officer recorded that this latter incident caused him to miss the 'peg' at 1.30am, but he made no record to explain why pegging from 1.55am to 4.58am had been missed – night patrol officers instructions require them to record all events and to record the reason for missing pegging.

There remains no explanation as to why the officer failed to peg and this must raise doubts as to whether patrolling was actually taking place.

The Morning Count

The night officer stated that he commenced his morning count at 5.45am. He also said that this count took him between 30 to 45 minutes to complete. The night officer said that he would have observed every prisoner and that he was able to see in the cells using the available natural light. The sun would have risen at 7.15am that morning. Many of the staff who attended the incident at 9.30am advised that, as they looked through the cell door, they were able to see the ligature from which the man was suspended. When found, the man was cold and rigor mortis had already set in. The condition that the man presented when found would tend to indicate that he had been dead at the time of the night officer's check.

I am therefore surprised that the night officer did not discover the man during his morning check of A-Wing. Whilst I am not suggesting that this would have prevented the man's death, I have doubts as to the effectiveness of this count or indeed whether this check was ever carried out. This is compounded by the fact that the night officer signed and timed his Report of Night Patrol at 6am, when it must have been completed later than that, as he acknowledged. His statement suggesting others routinely timed their reports at 6am was not supported when these other reports were studied. Many contained different timings.

Handover from Night to Day Staff

There are clear directions contained within the establishment's night orders as to how staff should hand/take over duty in the mornings. Unfortunately, these orders do not seem either to have been read or complied with on this occasion.

Day staff seem to drift into the establishment as they deem fit and this has the undesirable effect that night staff tend to go off duty at different times. In terms of management of the handover, this must prove extremely difficult and, in the event of an incident occurring or being discovered, almost impossible to manage effectively.

The day officer was not due to start her shift until 8am on 10 October, but had come in early to relieve the night officer. She had not been tasked to relieve the night officer that morning, in fact no officer had been allocated that duty. Although the day officer had received training, she was probably not confident of what was required of her that morning as she had never previously taken over duty from a night officer.

The fact that the night officer had stated that he had just completed a count of the wing should have made no difference to her. She had been made fully aware during her training of what was required of her when taking over a prison wing. She knew that signing the wing number record signified that a count had been completed and that she had accounted for all prisoners in her area. Her statement that no officer in her experience carried out a count in the morning is not a valid excuse for failing to do so.

I am of the opinion that, even if these counts had been completed in accordance with requirements, the man's life would not have been saved. However, he would and should have been found earlier than he was.

The Incident

A-Wing followed its normal regime for Sunday morning and staff started unlocking prisoners for them to collect medication. The day officer looked through the observation panel of the man's cell door and saw him hanging. Instead of immediately raising the alarm, she called to her colleague, the second day officer. He looked into the cell and called to the third day officer. The third day officer attended, looked into the cell, and raised the alarm by calling the emergency number from the telephone in the landing office.

None of the day officers entered the cell until the arrival of a responding Senior Officer. Upon his arrival, the second day officer unlocked the cell door whereupon the fourth day officer, closely followed by the Senior Officers, entered the cell. What is of serious concern is that no one up to this point entered the cell to examine the man to ascertain whether he was still alive.

PSO2710 advises all staff that, on discovery of a person hanging, they should enter the cell, cut the prisoner from the ligature, check for signs of life and, if the prisoner is not breathing and has no pulse, attempt resuscitation unless rigor mortis has clearly set in.

I accept that the man was already dead. Had this not have been the case, staff's failure to respond as per PSO2710 might have caused a decisive delay in the chances of saving him.

When the cell was entered, a further delay occurred in cutting the man free of the ligature while staff obtained a suitable cutting implement. The man's body was, however, supported while this was happening.

Once the alarm was raised, all appropriate staff, including emergency medical staff, responded extremely quickly and on arrival followed correct procedures in dealing with a prisoner found hanging from a ligature. The duty doctor arrived promptly and confirmed that CPR was unnecessary.

Management of the Scene

The incident scene was effectively managed and the requirements of both Prison Service Orders and preservation of evidence were fully followed.

Immediate Action Taken by Establishment

The governor in charge for the day and the duty governor attended the scene and, having completed an assessment, correctly withdrew to open the establishment's Command Suite and initiate the prison's Contingency Plan for Deaths in Custody. A Command Suite log was maintained throughout the incident.

Management and staff effectively followed these plans. A staff hot debrief was held, Staff Care and Welfare facilities were provided, reviews were carried out on prisoners subject to F2052SH monitoring and liaison was effected with all relevant outside agencies.

Contact was made with the man's family, and this contact was maintained including an offer for the family to visit the prison and assistance offered with funeral expenses.

Level of Compliance with Authorised Procedures

Pentonville has an effective suicide prevention policy and team. The F2052SH system is well managed and effectively administered. The Suicide Prevention Policy and Anti-Bullying documentation and systems fully comply with the requirements of national policy. I have no concerns in respect of these policies. However it is apparent that these policy documents are not fully understood by all staff.

Pentonville's contingency orders covering deaths in custody were found to be effective and correctly applied by the establishment.

I found that the emergency medical response procedure in place within the prison was of a particularly high standard. All staff I spoke to were fully aware of the system and how to initiate it. I found it to be fast and effective and am confident that, when deployed correctly, it would be able to effectively deal with most medical situations.

Maintenance Issues

I carried out a check of the man's cell call bell and found that it was faulty. When the call button was pushed, the light outside the cell illuminated, as did all lights on the main alarm panel on A1 landing. However the audible alarm failed to sound. Although there is no suggestion that this had any bearing in this case, it is of concern that, had the man wished to speak with someone, he might have had difficulty in attempting to alert staff.

Local Recommendations

The Governor should consider introducing anti-ligature knives as a standard piece of equipment to be carried by all staff who might be first on scene when a hanging is discovered.

The Governor should commission a review of the establishment's Night Orders to address the issues raised by this report in respect of compliance, training, briefing, roll checks, reporting procedures, handover systems and the discrepancy within staff shift timings at weekends.

The establishment should produce an information sheet, to be given to prisoners subject to licence recall at the point of their reception, to explain the system and the appeals procedure. In addition, the establishment's induction process should be reviewed to include this information for prisoners to whom it applies.

The Governor should commission a review of the system used in advising prisoners of their sentence calculation with a view to implementing a system which not only provides privacy, but also offers support to the individual should they require it.

The Governor should commission a review of the A-Wing cell bell system and of the checks used to ensure the system is working. The current system of reliance on cell fabric checks is not sufficient as in this case it failed to identify the problem.

The Governor should commission a training needs review of his staff in respect of:

- First aid training.
- First at the scene of a serious incident.
- Night duty – staff responsibilities.
- Suicide prevention – policy awareness.
- Anti-bullying – policy awareness.

Recommendations Regarding Staff Performance

The Governor should consider commissioning a disciplinary investigation into the actions and conduct of the night officer to address:

- Why there was a three hour gap in pegging on the night of 9/10 October without explanation on his Night Report sheet;
- Why he recorded that he completed a wing count at 6am when his count, by his own admission, was not completed at that time;
- Why he advised the day officer that she did not need to conduct a wing count that morning.

The Governor should consider commissioning a disciplinary investigation into the actions and conduct of the day officer to address:

- Why she did not conduct a wing count on the morning of 10 October, which she was aware she was required to do;
- Why she made a false declaration in signing the centre numbers sheet to confirm that she had completed the count and that all prisoners had been accounted for.

Prison Service Comments on Recommendations Regarding Staff Performance

In its response to the Ombudsman's draft report dated 27 June 2005, the Prison Service stated that disciplinary investigations against the two above named members of staff had been initiated in January 2005. Those investigations, along with subsequent follow-up action, have now been completed.