Investigation into the circumstances surrounding the death of a man at HMP Pentonville in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

December 2009

The man was found hanging in his cell at HMP Pentonville just before 9.00am on 29 December 2008. He had used a torn bed sheet as a ligature and attached it to the window bars. A prisoner, on his way to move into the cell, discovered the man and called for staff to help. The officers on the landing and healthcare staff responded quickly but they could do nothing to save his life. He had been in the prison for less than a week. My colleagues and I would like to extend our condolences his family and all those affected by his loss.

The investigation was carried out by one of my investigators. The Primary Care Trust (PCT) were asked to carry out a review of the man's clinical care. Following various delays and the resignation of one clinical reviewer from the PCT, the Deputy Chief Executive at East London Foundation NHS Trust completed the review on behalf of the PCT. I am grateful to the clinical reviewer for her assistance. The clinical reviewer experienced some difficulty interviewing and getting information from relevant staff and this too contributed to a delay in completing her report. The final review was received by the Ombudsman at the beginning of September and I apologise for the delay this has caused in publishing my own report.

The Governing Governor of Pentonville appointed a governor grade as liaison officer with the investigator. Another member of staff from Pentonville worked with the appointed governor to ensure that the investigation process ran as smoothly as possible. I would like to the Governing Governor and his liaison team for their assistance and co-operation with the investigation.

I make seven recommendations including those made by the clinical reviewer. Additionally, the clinical reviewer has recommended that staff from the wing and from healthcare involved in trying to resuscitate the man should be commended for their efforts. I am pleased to note that following receipt of the draft report, all the recommendations have been accepted.

Deputy Prisons and Probation Ombudsman **December 2009**

CONTENTS

SUMMARY

The man was a foreign national prisoner who was seeking asylum in the United Kingdom. In September 2008, he was arrested and remanded to Brixton prison. His case was transferred from the magistrates to the crown court, following which he was remanded to Pentonville prison. He had been in Pentonville for six days when he took his life.

There is very little information in man's prison files. He did not come to the attention of staff for any adverse behaviour with the exception of an altercation with another prisoner at Brixton. He was assessed as a low risk prisoner for cell sharing, he was on standard regime and was not thought to be at risk of harming himself by either prison.

However, following his death several sources of information suggested a history of mental health concerns although there is no information as to what they might have been. When the records from Brixton and Pentonville were collated further references to mental health issues were found. Due to various reasons I explore later in the report, they were never communicated between the relevant departments. With the information from all sources being scant, I am unable to comment on whether appropriate diagnosis and treatment for mental health problems, if relevant, would have changed the outcome for him.

The post mortem concluded that his death was from hanging. The toxicology report found that he had high levels of alcohol in his system. It has not been possible to confirm how or why he drank this level of alcohol. As someone who was described as a devout Muslim, the use of alcohol and the taking of his life is even more inexplicable as both are prohibited in Islam.

Having only been at Pentonville for six days, and it being the Christmas period, it has been difficult to get any significant information from staff about his behaviour and demeanour. From the interviews with staff, who had little or no knowledge of the man, there were no indications of self harm. More usefully perhaps, were the interviews with two of his friends in prison. Both friends saw him the night before he died and neither had any indication or concern that he was going to take his own life.

From what evidence there is, it appears that his death could not have been foreseen.

INVESTIGATION PROCESS

1. The office asked for all the relevant prison documents including man's core prison records and medical file. The investigator also visited the prison to carry out interviews and met a member of the Independent Monitoring Board (IMB) and Prison Officers Association (POA).

2. Notices to staff and prisoners were sent to the prison to be displayed. They invited anybody with information to talk to the investigator. Apart from the staff and prisoners whom the investigators identified, nobody else came forward with information for the investigation.

3. A review into man's clinical care in prison was commissioned and initially started by a clinical reviewer on behalf of the PCT. However, she left her post and the review was passed to the Deputy Chief Executive at East London Foundation NHS Trust. There were various reasons for delay and the final review was received by the office at the beginning of September. The reviewer made several attempts to speak to healthcare staff at HMP Brixton and interview a nurse at HMP Pentonville who was part of the emergency response. The nurse was on a period of sick absence and could not be interviewed. Additionally, a Staff Nurse did not attend her scheduled interview and an agency nurse who attended the man's cell during resuscitation no longer works at the prison. Unfortunately, these attempts to interview staff added to the delay and meant that the reviewer was not able to progress all lines of enquiry.

4. HM Coroner for Inner North London was informed of the investigation. The Coroner has kindly shared the post mortem with the investigators. He will receive a copy of this report. A pre inquest was been scheduled for 14 September 2009.

5. The man's next of kin live in Pakistan. Through the efforts of the Imam and Governor at Pentonville, two friends in England were identified and informed of his death by the Prison Service. One of the Family Liaison Officers has been in contact with one of the friends who kindly acted as a liaison with his family. They were offered the opportunity to be involved in this investigation and, via his friends, have asked the investigation team the following:

    1. How did he die?
    2. Why was he in prison?
    3. Was he beaten? Is there any evidence of bullying/threats against him?
    4. Could the people he had been involved with in connection with the criminal charges have threatened him or got someone to harm him?

    I hope that this report addresses their questions and tells them more about the last week of his life.

HMP PENTONVILLE

7. Pentonville is a Category B prison in North London. It serves the local courts in North East London and currently holds up to 1,152 adult male prisoners either on remand, convicted but unsentenced or sentenced.

8. As with other local prisons there is a high rate of movement of prisoners through reception. In their 2008-2009 annual report, the Independent Monitoring Board (IMB) noted that there are often more than 100 prisoner arrivals and departures on a single day and about 7,500 prisoners a year start a period of custody at Pentonville. The IMB also wrote

> "[The] No 1 Governor remains determined and clear in his objectives, and has impressed us with his accessibility to prisoners and staff. We are pleased to report that his sustained efforts and those of his staff over the last two years have continued to yield significant benefits …"

9. In relation to areas which link to the man's circumstances, the IMB report comments,

> "… the safer custody team has been very professional and supportive, learning from each of these incidents [two previous deaths] with the aim of reducing the risks of future cases. The number of prisoners on open ACCTs[1]… has fallen, enabling better scrutiny of those who really should be regarded as being at high risk. The second area is the First Night Centre (FNC) and the IMB reports as follows, "The FNC opened in July 2008, continues to develop. New prisoners arriving at Pentonville are particularly vulnerable to self-harm or suicide. The effort prison management puts into improving the experience of prisoners arriving in a prison for the first night and initial few days is crucial to keeping safe those prisoners and preparing them for life inside. The FNC should demystify the prison experience … and the risk of suicide or self-harm is highest at this stage. The FNC enables prisoners who need support and to understand and survive the process and direct prisoners to programmes and prison initiatives to give the prisoner the hope of rehabilitation".

The full IMB report, and previous reports can be found on their website: www.imb.gov.uk.

10. Her Majesty's Chief Inspector of Prisons, carried out an inspection of Pentonville in May 2009, but her report is yet to be published. The last inspection was an unannounced one in June 2006. I do not go into the details of the report given the length of time since it was issued and the fact that the latest report is imminent. Further information can be found on the Inspectorate's website: www.justice.gov.uk/inspectorates/hmi-prisons

[1] Assessment, Care in Custody and Teamwork (ACCT). A monitoring form and process for supporting prisoners at risk of harming themselves.

11. Since this office took over responsibility in 2004 for investigating all deaths in prison custody, there have been 14 deaths at Pentonville. There were four deaths due to natural causes and nine apparently self-inflicted deaths prior to this man's death. Two previous deaths, in 2005, were similar to in that their post mortem results showed the presence of alcohol and both had been at Pentonville for a short time.

KEY FINDINGS

12. The man was arrested in September 2008. His police custody record shows that he saw a doctor in relation to a foot injury for which he was taking antibiotics. The record also shows that he said he had a mental health condition for which he took medication. Although there is a note that his antibiotics were packed in his property, there is no mention of the medication he took for the mental illness, nor further explanation as to what this might have been. The following day, he was remanded into custody at HMP Brixton in London.

13. At Brixton, a member of staff completed the man's Cell Sharing Risk Assessment (CSRA) with. Part of the form asks about previous drug or alcohol abuse and he answered 'no' to both questions. Additionally, there are questions about previous self harm monitoring and again he responded 'no'. He said that he did not have any concerns about sharing a cell and was assessed by the officer completing the operational sections of the form, as low risk[2]. The officer suggested that he share with a Muslim prisoner. The medical section of the form assesses him as medium risk but does not give any reasons to substantiate this. There is no further information in the man's medical records. Indeed, in the records provided to the investigator, there are no entries between his arrival at Brixton and 2 October.

14. On 29 September, as part of his prison induction the man was interviewed for the London Initial Screening and Referral (LISAR) assessment, which assesses any needs or issues for example housing, employment or health. It is carried out by civilian members of staff known as LISAR clerks. The man answered 'yes' to a question about any mental health problems in the past or present, but there is no further explanation. He also answered 'yes' to having a physical health problem. In response to the question "what medication are you currently on?" it is written "tablets – not sure what called. Not sleeping". It is therefore unclear whether the medication was for physical or mental health problems or referred to the antibiotics. The LISAR form notes that the man was helped to complete an application to see the doctor and dentist, although no copies of the applications were provided.

15. The medical records from Brixton show 13 contacts with healthcare staff. These contacts include treatment for headaches, dry skin, stomach ache and an infected toe ulcer. There are also entries relating to smoking cessation. More significantly there is an entry on 29 October. It records,

> "Hx [history] of low mood and angry feelings. Poor communicant due to language difficulty. Says he has been thinking a lot, court case due next week. Cannot sleep well but has no thought of self harm and no previous hx of DSH [deliberate self harm]. Appears agitated, mood low, no thought disorder, no auditory hallucinations. Review in 4 weeks."

[2] Risk factors are based on the rate of risk of harm to others.
Low Risk – No current indication/evidence of risk, suitable for multi-cell location.
Medium Risk – No immediate risk, but situation will need to be reviewed regularly.

16. The medication prescribed was Hydrocortisone cream (for dry skin) and Mirtazapine (an anti-depressant).

17. The four week review date would have been 26 November, but the record on that day, only shows information about smoking cessation. In fact the next recorded appointment he had with a doctor after 29 October, was on 18 December and there is no mention of depression, mental health or the prescription of Mirtazapine.

18. The wing history sheets do not give much information about his time at Brixton, in fact there are only three entries. The first two, written in September, were about his reception into prison and the wing. The third, written on 21 November, related to a fight that he had with another prisoner. His medical record shows that he received some treatment for an injury he sustained.

19. Following the man's death, an Assistant Ombudsman spoke to the Imam at Brixton. The Imam told the Assistant Ombudsman that the man regularly attended Muslim worship and would also normally go to the prayer and study group. He described him as a quiet person but that he always appeared "to be okay". He added that whenever he asked him how he was, he would reply that, "he was well". The Imam did not feel, in his opinion, that there was anything in his manner to suggest he was depressed. The Imam said he viewed the man as an active person in that he took the opportunities offered to him, such as education, and always came to the prayer and study group without having to be "chased along".

20. The man's case was transferred from the magistrates court to crown court. In December 2008, he attended Crown Court. His full medical record should have transferred with him but it arrived without a copy of the electronic record which held all his relevant information. Additionally, perhaps because of the Christmas period, there is no evidence that it was requested by Pentonville.

21. On his reception to Pentonville, the man was placed on the third landing on 'A' Wing (A3). 'A' Wing is the induction wing where prisoners, whether transferring in from another prison or arriving in custody for the first time, spend one to two weeks. The '3's' landing is specifically for prisoners arriving for the first night in Pentonville. Prisoners are then moved around the wing as space becomes available and, after a week or two, they move to a main residential wing. 'A' wing has places for nearly 200 prisoners.

22. As part of the reception and induction process, the man was seen by healthcare and officers. He had another CSRA in which he was assessed as low risk and suitable to share with another prisoner. It was completed by an officer who also completed other areas of the induction process. The man asked to share with another prisoner, but that prisoner was sharing with his cousin at the time and did not want to change. At interview, the officer thought that she might have been the member of staff who allocated his cell, but she could not remember anything specific about the man.

23. A Registered General Nurse (RGN) who is currently the Ward Manager at Pentonville, was at the time of the man's death the charge nurse responsible for managing the staff on duty, and maintaining standards and quality of care. The RGN completed the healthcare reception screening (also referred to at Pentonville as Grubin 1) with the man. As mentioned, the record with his medical history had not arrived from Brixton and so the RGN had only the information from the man. The RGN did not feel the language barrier was a problem when interviewing him and thought the man understood enough to complete the assessment. He confirmed that other prisoners would sometimes be used as interpreters if there were difficulties. The RGN also said that the prison had a new contract for interpreting services with The Big Word, although after interviewing several staff it did not appear that this was well known.

24. In the screening 'history' section of Grubin 1, it notes that the man had drug misuse behaviour, drug addiction maintenance therapy in the form of methadone and that he was under ACCT processes. It goes on to record that he was not receiving medication at the time, that he had a depressive disorder but no thought of self harm and was depressed. He also said he had epilepsy but then said he did not have any medication for the condition.

25. This information was contrary to the information and evidence already given to the investigator and clinical reviewer, and so the RGN was asked in interview if he could explain his findings. He said that the record was incorrect. He clarified that after the man's death they discovered that, due to the way the computerised system was set up, if you were to click the computer mouse too quickly or move it accidentally after making a selection it could choose the wrong option. That is what happened when the RGN selected the ACCT option and he confirmed that the man was not on an ACCT. The RGN also explained that there was no option to choose 'low in mood' and that was why he put 'depressive disorder'. Although when asked, he did explain that there is a 'free text' box where additional comments could be entered but that was not "normal practice".

26. The RGN said that in his view, nothing "alarmed" him about the man and he just appeared to be "low in mood", which he felt was quite normal for people arriving in prison. The RGN said he did not have any concerns about the man's mental health and otherwise he would have referred him to the mental health team. The clinical reviewer asked about a comment made by the man which is recorded in his notes. When he was asked about his next of kin, the man told the RGN that his wife was dead and that he had killed her. The clinical reviewer asked if this comment had prompted further exploration. The RGN said that it had not because it had come across as a "throw away remark", and he understood the man to be on remand for drug related offences rather than murder. The RGN thought that in hindsight maybe he should have explored the comment further.

27. The RGN referred the man to the doctor because he had not arrived with a prescription chart and, in his experience, prisoners will sometimes tell the doctor something different than they tell other healthcare staff. This seemed to be the case when asked about drug misuse and epilepsy. The RGN said that the man told him he had misused drugs and was taking methadone as a

28. The following day, 24 December, the man moved from the third landing to the fourth (A4). He also completed another LISAR assessment. One of the questions concerns disability. He answered 'yes' and told the staff he had a mental illness but, as in Brixton, there is no further information. The LISAR clerk who completed the man's form told the investigator that they can complete up to 40 a day and she could not remember anything specific about him. She did however remember that he told her he could not work due to a mental health problem. It was at this point that she ticked the box referring to disability. LISAR staff are not medically trained and not qualified to diagnose an illness. They rely on information given by the prisoner and then make appropriate referrals. In this instance, the man was referred to an external mental health agency. No referral was made to the prison's healthcare. In the interview with the RGN, the investigator asked for clarification between the LISAR assessment information and healthcare assessments and information. It was clear that the RGN was not aware of the LISAR clerks or the screening.

29. The Imam saw the man on his transfer to Pentonville. During a conversation with the investigator the Imam said that he would have seen the man during his induction so that he was aware of the facilities and activities for Muslim prisoners. In a statement the Imam later provided, he reiterated that his contact with the man was brief since he had not been in Pentonville for long but he had been on list for the Muslim service on Friday 26 December. The Imam said that the man had attended, along with approximately 180 other prisoners. The Christmas period would have meant that there was a limited regime in place.

30. Another registered nurse saw the man on 28 December to interview him for the secondary health screening (Grubin 2). The investigation team have been unable to interview the registered nurse and so have relied on written evidence. In her statement following the man's death, the registered nurse said that when she saw the man he appeared to be "in good spirits and was smiling and making good eye contact". He had complained of an itchy head, stomach pains and problems sleeping. The registered nurse told him he would need to see the doctor and explained how to fill in an application to do this. She explained that he would not be able to see a doctor that day because it was a Sunday. The registered nurse added that the man spoke poor English but that she had been able to communicate parts of the assessment and complete the screening. The man denied any mental health problems and, in her view, was not behaving inappropriately nor appeared to be depressed.

31. At approximately 10.30am on 28 December the landing officers carried out the cell fabric checks (CFC)[3]. An officer signed for the checks on the man's landing. The officer signing the checks could not remember if it had been himself or a colleague working on the landing or both who checked the man's cell. The CFC checklist only records the state of the landing as a whole and not the individual cells. On 28 December, the checklist showed that the cells on A4 were 'clear when checked' (CWC) suggesting that there was nothing to report.

32. One of the man's friends in prison told the investigators that the man had visited him in his cell during the evening of 28 December. He did not have a kettle and the man did and had brought him some hot water. They had a cup of tea and a cigarette. The friend said he did not notice anything different in the man's mood or behaviour. The friend had told prison staff that he believed the man was waiting for a response to a bail application and was surprised that he had taken his own life. (No information regarding a bail application was found in his records.)

33. Prison staff also spoke to another associate of the man. The associate has since been released from prison and the investigator was unable to interview him. He told prison staff that he also saw the man on the evening of 28 December and had no indications or concerns that he would harm himself.

34. The man would have been locked back into his cell with the rest of the unit after the evening meal time and association. He was alone in a double occupancy cell. Once all prisoners are locked in their cells for the night a roll check is carried out to ensure that everybody is accounted for. According to the roll check log, a check was made at 9.00pm by an officer. (During the interview it was explained that, although the roll check log states "21h00", the checks actually take place around 8.00pm so that the roll check count is confirmed before staff go off duty at 9.00pm.) The officer who did the roll check told the investigator that, although she remembered carrying out the roll she could not specifically remember the man.

35. Two officers were on night duty. The night officer should make a roll check once during their shift and again in the morning before handing over to day staff. Both night duty officers have provided the investigator with a statement to say that they were on duty and carried out the roll checks but cannot remember which landings they each checked. The man did not press his cell bell during the night nor come to the attention of staff in any other way.

36. Two further officers arrived on the wing at the start of the day shift on 29 December. One signed for the 7.30am roll check. However, when the investigator spoke to him, he said that it was his night duty colleague who checked the man's landing. The night duty colleague has provided a statement to say that he checked the fourth and fifth landings on A wing at approximately

[3] The purpose of CFCs is to check the locks, bars, bolts of a cell as well as ensuring fittings etc. are in working order and secure. Officers may look around the cell for unauthorised items but this is not the main purpose of the CFC.

6.45am and did not find anything of concern. It can be assumed from this statement that the man was still alive at the time.

37. Two further officers were both on duty on A wing that morning. This would have been shortly before 8.50am. The officers were unlocking prisoners who were due to move cells. In interview the officers said that another prisoner on A wing was due to move into the man's cell. One of the A wing officers told the prisoner to make his way to A4 landing and wait for cell 15 to be unlocked.

38. The two A wing officers then moved to the next cell and were talking to some other prisoners when they heard the prisoner who was due to move, shouting down to them that somebody was hanging in the cell. Both officers made their way quickly to the man's cell. A third officer was also on the wing and responded when he saw his colleagues running to A4 landing. The officers arrived at the cell, the third officer unlocked the door and they went in. The man was hanging from the window bars. The second A wing officer alerted staff by using her whistle and in the meantime, the third officer lifted the man to take his weight off the ligature, a bedsheet, while the second officer cut it with his anti-ligature knife[4]. The officers laid the man on the floor and put him in the recovery position and the first A wing officer used his radio to call for assistance. The third officer said in interview that as he was taking the ligature from the man's neck, healthcare assistance arrived.

39. The registered nurse who carried out the second healthscreen (Grubin 2) was in the adjacent wing when she heard the alarm over the radio. She collected the medical emergency bag and arrived within a few minutes. The registered nurse checked the man's vital signs, observing that he was not breathing and she could not find a pulse. She started chest compressions and was joined by an agency nurse a few seconds later. The two nurses continued to administer cardio pulmonary resuscitation (CPR). A senior healthcare manager was on his way to a morning meeting when he responded to the call for assistance. After assessing the situation he called for an ambulance and went to get a defibrillator[5].

40. The acting charge nurse heard the call over the radio and responded to the wing with the staff nurse. The healthcare manager arrived at the cell with them and applied the defibrillator. The acting charge nurse gave oxygen to the man and then took over the chest compressions while the acting charge nurse managed his airways. The defibrillator did not advise a shock, so CPR was continued by healthcare staff until the London Ambulance Service paramedics arrived at 9.06am. Timings vary in the records but the air ambulance (HEMS) arrived between five and ten minutes later and their staff helped with the resuscitation attempt. At 9.30am the emergency services staff could do

[4] Also referred to as a 'cut down' or 'anti-ligature' knife. It is a knife designed make the cutting of a ligature easier.

[5] A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer.

nothing more and stopped resuscitation. The air ambulance doctor pronounced the man's death.

41. The death in custody contingency plans were carried out including a hot debrief for staff involved in finding and resuscitating the man. His cell was sealed, as required by the plan, for the police to attend, but nothing suspicious was found. There was no suicide note. The man's family were concerned that he had been threatened or hurt by somebody or at the request of somebody outside of prison. There is no evidence to suggest that this was the case. He was on his own in his cell when he died.

Events after the man's death

42. The Governing Governor attended the prison. He carried out the 'hot debrief' for staff who had been involved in responding to the man's death and later held a full staff meeting to inform all staff of the man's death.

43. All prisoners on open ACCTs were reviewed and all those who had ACCTs closed in the previous three months were assessed as well. The man's known co-defendants at Pentonville were interviewed and any risk was considered.

44. The prison could not immediately identify the man's next of kin. Their extensive efforts included speaking to his co-defendants, speaking to the Imam at Brixton, contacting UKBA, contacting the numbers on his pin phone and visiting his last known address. Eventually the prison was able to contact two of his friends. The Imam acted as a liaison between the prison and man's friends and accompanied them to view his body. The man's friends have since visited the prison and were liaising with his family. The prison Governor offered financial assistance for the repatriation of the man's body and for one of his friends to accompany him home.

45. The man's friends told the Governor that he had previous mental health problems but that they were not "routinely visible but did occur when under some pressure". They confirmed that the man had been actively seeking asylum. The information provided to the prison from UKBA referred to his health problems being physical rather than mental. This would not have been first hand information to the person providing the information and may have been incorrect.

46. The man's associate in prison who had spoken to staff, told them that he had heard what sounded like a cell fight in the vicinity of man's cell at approximately 11.00pm on the night of 28 December. The member of staff checked the wing observation book, as did the investigator, but there is no record of any incidents. One of the night duty officer's also said she could not recall any sound or noise.

47. The man's friend who spoke to the investigator could not believe that the man had taken his life particularly because he had spoken of his love for his children. The prisoner thought that the man's cell was open in the morning of 29 December and that there were prisoners walking about. He added that there were two white prisoners on the landing near to the man's cell. The

48. The investigator spoke to the prisoner who was in the cell next to the man. The second prisoner said that he did not know him. He said he did not hear any fighting or shouting the night before his death. He also heard nothing during the morning until he heard the officers responding to the emergency call. The man was in the cell on his own and it is unlikely that the noise was from his cell.

49. The investigator also spoke to a prisoner who shared a cell with the man for one night. The third prisoner could not remember the specific night, but said he did know the man. The third prisoner said that the man's English was good enough to get by, but the two of them spoke in Urdu which they could both understand. The man had told him about his alleged offence and the third prisoner remembers writing a letter for him to his solicitors. The man had told him that he could not understand the law in Britain and wanted his solicitors to arrange an interpreter for his court proceedings.

50. The third prisoner also explained how the man told him about his enemies in Afghanistan and how it was they who sent a parcel of drugs to him so that they could get him sent to jail and deported back to Afghanistan where they could kill him. The investigator asked about the man's general behaviour. The third prisoner thought that the man always looked sad, which he thought was because of the risk of deportation and his enemies in Afghanistan. He added that he did not associate much with him at first. He said the man would not make the first contact with others although he would talk to anybody. He added that the man was not used to 'prison etiquette' and so would ask questions of other prisoners that would not normally be asked. The investigator asked if this led to any bullying or threats. The prisoner did not respond fully to this, but spoke more generally about his dealings with the man. He wished that, as a fellow Muslim, he had offered the man more support, explaining that in the community he would have treated him as an elder and with more respect.

51. The post mortem gives the man's cause of death as "Hanging". His family were concerned that there had been some violence, but the post mortem comments that there were no significant marks of violence other than the ligature mark. The toxicology report shows high levels of ethanol (alcohol) in his system. He showed levels of 2.8g/L in his blood. The interpretation given is that the legal limit of blood ethanol for driving is 0.8g/L and concentrations above 3g/L are associated with serious toxicity.

52. There is no firm evidence to indicate how the man obtained the alcohol. However, on 25 December 2008, another prisoner, who was a cleaner on B wing, was removed from A wing on several occasions. Later he was discovered to have been drinking and was placed on report by staff. The B wing cleaners often go to A wing as part of their duties. One of the investigator's liaison officers said that he had spoken to the prisoner regarding the man's use of alcohol. The prisoner from B Wing said that he took alcohol

53. A record of cell searching on A Wing, shows that the cells searched on 21, 22, 26 and 30 December 2008 found no unauthorised items. Security records show five entries of potential 'hooch' finds in December. One of these, on 1 December, was on A Wing.

54. During a conversation with the investigator, the Imam said he was surprised that alcohol had been found in the toxicology results. He was of the opinion that the man was a devout Muslim and the use of alcohol is prohibited in Islam. Likewise, when the Imam spoke with the investigation team about the prohibition of alcohol in Islam, he thought it was out of character and could not comment on why the man had consumed it. He added that he was unaware of any issues in his private life that the man was trying to overcome.

55. The investigator spoke with the Principal Officer (PO) who has been in charge of A Wing and Reception (Admissions) since November 2008. The PO explained the new work he was implementing on the First Night Centre. At the time of the man's death only new prisoners, rather than those transferring from another prison, completed a first night induction checklist. The PO could see no rationale for not carrying out this process with prisoners transferring in as their circumstances might have changed and it would familiarise them with the systems in place at Pentonville.

56. The PO also redesigned the induction checklist so that it now includes more questions to prompt fuller discussion as well as a column to note any action which needed to be taken. A team of five dedicated induction officers has been formed. At least two officers will be on duty to work with new prisoners. The rationale is that the officers will have more knowledge and expertise in this area and thus be a better and more consistent source of information. This should in turn make the process of arriving at Pentonville easier for prisoners. There is no suggestion that the procedures in place before these new initiatives contributed to the man's death but I am pleased to note that work is being carried out which should improve the information obtained by and given to prisoners entering Pentonville.

ISSUES CONSIDERED

Clinical care

Medical records

57. The man's full medical record did not transfer with him from Brixton to Pentonville. Additionally, when the computerised printout of his medical history was sent from Brixton, there was no information about his first week in prison, including the reception screening information. This meant that Pentonville did not have his medical or prescription history and were working only with what the man told them.

58. That said, there is no evidence to suggest that his records were requested promptly by Pentonville staff either. Whether this would have made a difference to an appropriate assessment of any mental health concerns is difficult to tell. Nevertheless medical records should transfer with a prisoner.

The Head of Healthcare (at Brixton) should satisfy herself that medical records are transferred with all prisoners leaving Brixton.

The Head of Healthcare (at Pentonville) should ensure that systems for chasing medical records either from another prison or community GP's are adhered to.

59. The details entered onto the man's medical file during his reception into Pentonville were incorrect. This was explained as being a combination of computer error and lack of adequate list choices on the computer system. These records are essential for the care and treatment of prisoners and should always be accurate. Whilst I appreciate that room can be made for human error, there was more than one false or misleading entry in his reception screening assessment.

60. Additionally, from what the investigator and clinical reviewer were told, there are no adequate alternatives in the drop down lists. However, even if this is the case, there are free-text boxes where further explanation or clarification should be recorded. Saying that it is not "normal practice" to use the box is not acceptable when dealing with a person's health.

The Head of Healthcare (at Pentonville) should ensure that all staff are fully trained and competent in the use of computerised medical records and the use of free text boxes should be encouraged.

Mental Health

61. The clinical reviewer thought that the remark the man made about killing his wife during the reception screening was significant enough to warrant further exploration. However, it was perceived as a 'throw away remark' by the RGN who had no other information about the man's mental health or his family circumstances. We will never know why the man spoke in this way. It might have been a random expression or it could have been an indication of mental

The Head of Healthcare (at Pentonville) should explain the importance of exploring unexplained issues or unusual comments made during the assessment processes.

62. There is mention of mental health problems in the police custody record and the LISAR form from Brixton, but this would not have been known to Pentonville staff in reception. The man's friends also mentioned a history of mental health problems, but again this only came to light after his death.

63. The LISAR clerk at Pentonville noted a mental health issue and referred the man to an outside agency. After speaking to the clerk and a member of healthcare it was obvious that there was no joint working between the two departments or with the operational staff. Given the length of time the man was in Pentonville, he would probably not have had any significant mental health input, but there is a clear gap in communication.

64. A variety of people had information that the man might have had mental health problems. No further exploration was made and it is impossible to know what type or to what extent he had a diagnosable or treatable mental health illness. Had all the available information been shared, he might have been assessed earlier and received treatment if it was appropriate.

65. It is important that all departments share information to ensure continuity and appropriate care for prisoners.

The Head of Healthcare (at Pentonville) and LISAR clerk manager should ensure that there are systems in place to share information within the prison.

Consumption of alcohol

66. The toxicology tests after the man's death showed a very high level of alcohol in his system. From speaking to the Imams, this would seem to have been very out of character particularly because of his Islamic faith which prohibits alcohol. There is no information to suggest that he consumed alcohol at any other time of his life.

67. No alcohol was found in the man's cell when it was searched after his death. It is known 'hooch' was available on A wing during in December, but I am unable to confirm whether or why he decided to obtain it. It is also not possible to say when he would have consumed the alcohol. The clinical reviewer has commented that she was surprised that nobody realised he was intoxicated. However, after the 7.30am roll check (which is said to have taken place at 6.46am), there would have been no need for any staff to see him until later in the morning. Without knowing when the consumed the alcohol it is difficult to

68. The manufacture and consumption of 'hooch' within prisons is unfortunately an age-old tradition, particularly around the festive season. However, that he was able to obtain and consume such a considerable amount raises safety and security issues. The Ombudsman made similar comments in two previous Pentonville deaths in custody reports in 2005. I do not doubt that action was and is being taken to control the problem but nevertheless repeat the recommendation here.

The Governor should investigate the extent of alcohol production at Pentonville and establish a plan to deal with the findings.

Use of interpreters

69. The man's first language was Pushtu. The general understanding from staff interviewed was that he knew enough English to 'get by'. There are systems in place for staff to use interpreters through a contract with The Big Word. The staff who the investigator spoke to seemed generally unaware of the service and were not using it, preferring to rely on other prisoners who could speak the relevant language. This will not always be appropriate, particularly in medical situations, and staff should be aware of the professional services available.

The Governor should ensure staff have up to date knowledge of the services available to assist those prisoners whose first language is not English.

CONCLUSION

70. The man was in Pentonville for six days. With close to 200 prisoners on A wing, and many moves on and off the wing, it has been difficult to find anybody who knew him well or staff who had any significant contact with him. As a result, it is also difficult to know whether or not there was any obvious change to his mental health over the short time he was in Pentonville. None of the staff or prisoners interviewed for this investigation thought that he was at risk of suicide.

71. The man was not subject to ACCT either at Brixton or Pentonville. He was assessed as low risk for sharing a cell. There was no security intelligence that raised any concerns about his behaviour.

72. It is a sad fact that, in busy local prisons, unless prisoners stand out for good or bad reasons, staff have limited opportunities to have any meaningful interaction with them. The population in a prison such as Pentonville is high and transient, particularly in the first night centre. From the information available, there does not appear to have been any visible indication that the man planned to take his own life. Notwithstanding my recommendations about information sharing, I do not believe that prison or healthcare staff could have prevented him doing so. His reasons are unclear and may be linked to worries about spending a long time on remand.

RECOMMENDATIONS

Brixton

1. The Head of Healthcare should satisfy herself that medical records are transferred with all prisoners leaving Brixton.

   This recommendation has been accepted.

Pentonville

2. The Head of Healthcare should ensure that systems for chasing medical records either from another prison or community GP's are adhered to.

   This recommendation has been accepted.

3. The Head of Healthcare should ensure that all staff are fully trained and competent in the use of computerised medical records and the use of free text boxes should be encouraged.

   This recommendation has been accepted.

4. The Head of Healthcare should explain with staff the importance of exploring unexplained issues or unusual comments made during the assessment processes.

   This recommendation has been accepted.

5. The Head of Healthcare and LISAR clerk manager should ensure that there are systems in place to share information within the prison.

   This recommendation has been accepted.

6. The Governor should investigate the extent of alcohol production at Pentonville and establish a plan to deal with the findings.

   This recommendation has been accepted.

7. The Governor should ensure staff have up to date knowledge of the services available to assist those prisoners whose first language is not English.

   This recommendation has been accepted.