

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

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

January 2008

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 in 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 member of the Prison Service's London Area Office. An independent clinical review was conducted by a clinical reviewer from Prison Health. I am grateful to all members of the team for their work.

An investigator from my office liaised with the member of the Prison Service during this investigation. I have structured this report so that the member's investigation can be separately identified.

One of this office's Family Liaison Officers (FLO) telephoned the man's mother to inform her of this office's role and this investigation. I know that the FLO offered her sympathy and condolences, but I would like to take this opportunity to add my own sincere condolences to the man's mother, family and friends.

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

The investigation has revealed alarming failings in Pentonville's practices at the time of the man's death.

Although the actions the prison took in the immediate aftermath of the man's death were impressive, its initial contact with the bereaved family was very poorly handled. However, my greatest criticism is centred on this investigation's finding that the cell-bell system had been tampered with so that there was no audible alarm. I have added a final recommendation (recommendation 15) to the senior investigating officer's list to reflect my concerns on this score.

The first draft of this report was issued to the Prison Service, for its consideration, in June 2005. Before the draft could be copied to the man's next-of-kin, this office was instructed by the Metropolitan Police to suspend all further action pending consideration of a possible prosecution by the Crown Prosecution Service (CPS). In June 2006, the CPS decided not to prosecute.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN
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SUMMARY

The man had incurred many criminal convictions and had served many periods in prison custody. He reported that all his offences were drug related, and that he wanted help to address his drugs problem.

He was taken into custody at HMP Pentonville in April 2004 as a remand prisoner, charged with a number of crimes including motor vehicle related offences, handling of stolen goods, burglary and assault. He was convicted in July 2004 for a number of these offences, although the charges of burglary and assault were put aside to be heard on another day.

While in Pentonville, the man was in touch with a key worker from a team helping those with drug or alcohol related problems. The key worker arranged, with his agreement, for him to stay at a drug rehabilitation centre upon his release from prison.

His release date for the offences upon which he had been convicted was 10 October 2004, but as the Prison Service does not discharge prisoners at weekends, the release date was adjusted to 8 October. Before being released, however, he was first required to attend court on 7 October in connection with the outstanding offences of burglary and assault. The court did not proceed with the outstanding offences that day, but granted bail for him to reappear at a later date. As he was not due to be released until 8 October, he had to go from court to prison for the night of 7 October. Pentonville was overcrowded that night, so he was taken to Wormwood Scrubs instead. His key worker had arranged to escort him from Pentonville to the drug rehabilitation centre on 8 October. However, because he spent the previous night at Wormwood Scrubs, this arrangement broke down and he did not arrive at the centre until after the weekend and, due to inappropriate behaviour on his part, he was asked to leave.

At a late hour on 21 October, the man was arrested by the police and spent the night in a police cell. At Court the following day, he was remanded into prison custody and taken to Pentonville.

He arrived at Pentonville at just before 7pm on Friday 22 October. The Prisoner Escort Record (PER) form is a standardised form used when one agency transfers a prisoner to another agency. It contains a series of tick boxes to indicate possible risk factors applying to that prisoner. In his case, the police had marked his PER form with a number of warnings, including that he might be at risk of suicide/self-harm. On arriving at Pentonville, he received a First Reception Health Screen interview. During this interview, he was asked whether he had harmed himself in the past and also whether he felt he was at risk of harming himself now. He was recorded as denying any past incidents, or present thoughts, of self-harm. He was allocated a double cell on the 5's landing in the first night centre in E-Wing.

The man made two telephone calls that evening. The first call was to his girlfriend. Comments in their conversation suggested clearly that he was

considering self-harm. After completing that call he then telephoned his mother and spoke about his court case set for 27 October. He asked his mother to speak to his girlfriend to persuade her to give a statement to the police that might help him at his court case.

A prisoner in E-Wing who, as a Listener, made a point of speaking to newly arrived prisoners, saw the man on that Friday evening. He seemed distressed and so the Listener said that he mentioned this to two members of staff. However, only one member of staff on duty in E-Wing recalls any issue arising about the man that evening and that was to do with his medication. The officer said that no prisoner had mentioned to him any concerns about the man.

During Friday evening and through Saturday, four further prisoners recalled having contact with the man. One prisoner, who had a ten-minute conversation with him on Friday, said that he seemed fine. The remaining three prisoners all knew him; one had known him for an extremely long time. They described him as happy-go-lucky, but also someone who would sometimes have days when he would be rather depressed. None of them thought that he was a person who would take his own life.

Just before lunch on Sunday 24 October, the man's cellmate was moved out of their cell to go to another cell. This prisoner spoke no English and so it was arranged for him to share a cell with someone who spoke his native tongue. One of the officers involved in arranging this move asked the man if he was okay, to which he replied that he was. The officer told him they would try to find him a new cellmate after lunch.

Once prisoners had collected their lunch trays, they were locked into their cells and shortly after this the staff took their own lunch break. Due to staffing shortages, one officer, Officer A, agreed to forego his lunch break in order to act as lunch patrol officer for A and E-Wings. During the lunch break, he unlocked several of the prisoner cleaners for them to collect clean laundry for the prisoners in A-Wing. He said at interview that, from the landing where he was supervising the cleaners, he could observe the call bell alarm panel which would illuminate if any prisoner in either A or E-Wing were to press his cell bell. He said that no lights illuminated for any of the cells in E-Wing that lunchtime and so he had not visited that wing at all.

Staff returned from lunch at about 1.45pm and they all gathered for a briefing meeting. At the end of the meeting, the majority of staff went to A-Wing while Officers A and B went to E-Wing and they unlocked the cleaners. Officer B went to the wing office to deal with paperwork, while Officer A took one of the cleaners to A-Wing to collect E-Wing's laundry. By the time Officer A returned to E-Wing, the cleaners had finished their work and they asked if they could play backgammon. He allowed them to do so and there is some suggestion that he might have participated in a game. By his own admission, he certainly showed an interest in learning the rules of the game.

There is some disagreement about cell bell lights in E-Wing that afternoon. Two of the cleaners mention noticing that lights on the alarm panel were

illuminated. One said that lights were illuminated when he was unlocked at just after 2pm. Officer A said that he had noticed that lights were illuminated and he answered two calls from the 3's landing after he returned with the laundry from A-Wing.

It was one of the cleaners who discovered the man. The cleaner had gone to the 3's landing to give a prisoner a cigarette paper, as he had promised to do. The cleaner then noticed that a light was illuminated showing that a prisoner from the 5's landing had pressed his call bell. The cleaner went to the man's cell and saw him hanging from a ligature secured to the window frame. The cleaner shouted for the officers to come. The time was just before 2.30pm.

Once the alarm was raised, staff, including healthcare staff, responded without delay and a 999 call was made for paramedics to attend. Unfortunately, all attempts to resuscitate the man failed and a doctor who attended with the paramedics pronounced him dead at 3.08pm.

This investigation has revealed some disturbing failings. When found, the man's body was described as cold to the touch, his peripheries were turning blue and his clothing, which had been wetted when he passed urine, was beginning to dry. He had hanged himself from the window frame at the back of the cell and the cell bell is next to the cell door on the opposite wall – around 10 feet away. Clearly, he had pressed his cell bell quite some time before he was found. Officer A should have seen, and responded, to the call very much sooner. One of the man's friends was certain that his intention had been that he would be found and saved and that he would have engineered for himself a move to healthcare.

Other omissions have been identified in this investigation. The cell bell alarm panels were found to have been tampered with so that their audible alarms no longer sounded when a cell bell was pushed. The panels were reported to have been in this condition for many months, and it is inconceivable that senior staff could have been unaware of this fact.

Officer A's actions in unlocking prisoners when on his own during the officers' lunch break, was a serious breach of prison security, but his actions were found to be common practice. It is again difficult to believe that senior staff could have been unaware of this practice. Furthermore, it is unclear whether lunch patrol officers actually carry out patrols at lunchtime. Certainly, Officer A did not do so.

It was reported to the investigator as common practice that prisoners frequently press their cell bells for trivial reasons such as wanting hot water or a light for a cigarette. Moreover, it was reported that it is often the cleaners, rather than the officer, who respond to cell calls. These practices can only serve to diminish, in the minds of staff and prisoners alike, the importance and purpose of the cell call system.

Recommendations made in this report include: a review of working practices; an inquiry into the breaches of prison security, maintenance checks of the cell

bell alarm system; and an investigation into the abuse by prisoners of the cell bell system. A recommendation that a disciplinary investigation be carried out into the actions and inactions of Officer A was circumvented through that officer's resignation from the Prison Service.

Senior Investigating Officer's Report

Investigation Process and Methodology

On 2 November 2004, accompanied by the investigator from the Ombudsman's office, I attended HMP Pentonville and met with members of the management team. We were introduced to a Senior Officer (SO) A, the appointed prison liaison officer and received a full and in-depth briefing as to the actions taken by the prison regarding the death of the man, post-incident management, and contacts that had been made with outside agencies such as the Coroner's office and with the man's family.

I provided SO A with a list of my requirements and I was allocated an office to work from. 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 him with a list of additional documentation that he obtained without delay.

The investigator and I took the opportunity during the visit to plan the investigation strategy, discuss investigation parameters and agree individual responsibilities. We visited the cell where the man died and received a briefing about A-Wing's function and regime. I was later able to speak with staff and prisoners located in the wing to gauge if there were any underlying issues relevant to the investigation.

Whilst at the prison, the investigator and I met with representatives from both the Prison Officers' Association 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, a Detective Sergeant, and advised him of the Ombudsman's investigation and the areas that it would cover. I offered both my co-operation during the investigation and to share any information that might be relevant to his inquiry. The liaison established between police and myself proved to be very effective and I hope beneficial to both.

The Section Head (Substance Misuse), Prison Heath conducted a review of the standard of medical care provided to the man while in Pentonville. His report has been incorporated into this report.

I identified those whom I felt would need to be interviewed. During the inquiry, I formally interviewed 26 persons and have spoken to a further four with case notes taken. I have also spoken with a large number of other people within the establishment. However, I have 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 their co-operation during the investigation. Additional thanks are extended to SO A for

the assistance he provided whilst acting as liaison officer, a task he fulfilled to an extremely high standard.

HMP Pentonville

Pentonville was built 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 through 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, and the prison has a group to represent prisoners' families. The Rehabilitation of Addicted Prisoners Trust provides drug rehabilitation programmes. Pentonville is represented on the 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 23 October 2004, the prison held some 1,201 prisoners, 63 of whom were located in E-Wing.

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 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 being provided access to the Duty Medical Officer on their arrival in the prison.

Sequence of Events

Overview (Time Line)

In order to provide an overview, it is felt that it would be of assistance at this stage in the report to list the significant events of the man's period in custody, the discovery of him in the cell and the post-incident management. These events themselves will be covered in greater detail in the relevant sections of the report.

MAIN EVENTS:

January 2003	Released from Pentonville on conditional licence.
26 April 2004	Returned to custody in Pentonville on remand accused of a number of new offences.
27 April 2004	A release date of 24 July 2004 was set in connection with the revocation of the conditional licence.
14 July 2004	Found guilty at court for a number of the new offences. Received a 6-month sentence and a conditional release date of 10 October 2004.
7 October 2004	He attended Court and then taken to Wormwood Scrubs.
8 October 2004	Released on conditional licence.
21 October 2004	Arrested by police at 11.35pm.
22 October 2004	Ordered into prison custody at Court.
22 October 2004	Received into Pentonville at 6.54pm. Received First Reception Health Screen and assessed by duty doctor.
22 October 2004	Located into First Night Centre at 9.08pm.
23 October 2004	Assessed by Drug Detoxification Team.
23 October 2004	He refused Induction Programme.
24 October 2004	At 10.46am relocated to cell E5-08. At 2.30pm, he was discovered hanging from a ligature in his cell.

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.

Reception To Prison and Events Leading up to the man's Death

Friday 22 October 2004

The man was received into custody at Pentonville at 6.54pm on Friday 22 October. His Prisoner Escort Record (PER) and accompanying documentation from the police identified that he was judged at risk of suicide/self-harm and had drug/alcohol issues. This documentation also advised that he was considered to have medical problems and there were also warning signals for violence and carrying of concealed weapons.

His First Reception Health Screen was conducted by Health Care Officer (HCO) A, who knew him from his previous times at Pentonville. Asked at interview how the man had presented that evening, the HCO said: *'... he obviously wasn't ... very impressed at being back inside ... but I ... noted nothing out of the ordinary based on my ... previous dealings with him ... he was like most inmates that come through reception ... my recollection was that he told me he was hungry, and that was his main priority at the time, he said, "Guv'nor, I must have some food." And again from my recollection we had some light banter, might be to the effect: "Oh you again, what are you doing back?", "Yes, I know Guv'nor, what am I like?" ...'*

The HCO did not know that the man had previously been subject to F2052SH procedures. He said though that he always asked prisoners whether they had harmed themselves in the past. He had answered that he had never self-harmed and did not feel like doing so that day. The HCO said: *'I had no concerns [about the man] whatsoever ... we have to take [prisoners'] answers on face value unless we know otherwise ... we are required to read a paragraph [on the form] which says: "For some people coming into prison can be difficult and a few people may find it so hard that they consider harming themselves, do you feel like that?" I ask everyone that question and I asked [him] that question and he stated that he would be fine.'* Asked whether he had seemed depressed in any way, the HCO said: *'He didn't strike me as being depressed ... there was nothing to indicate that he was, anything other than just a bit pissed off ...'*

I concluded by asking the HCO if he had considered opening an F2052SH for the man. He said: *'... I have given this some thought and even looking back on the conversation with him, with hand on heart [I have to] say there was nothing that led me to believe that there was a self-harm issue at the time.'*

Prison Doctor A was the duty doctor on 22 October and he examined the man after he was seen by the HCO. The man declared that he had a drug addiction and so the doctor prescribed Diazepam for that night ahead of the formal assessment by the Detoxification Team the following morning. This was in line with Pentonville's reception protocol. Had he appeared depressed or suicidal, the doctor would have opened an F2052SH. However, there were no indications of this in his case.

Part of the reception process was to undertake a Cell Share Risk Assessment. This is to gauge the type of accommodation that should be allocated to a prisoner and whether they pose any threat to those they might be accommodated with. The man's assessment indicated that he was considered as medium risk, meaning that there was no immediate risk, but that the situation would need to be reviewed regularly. Sections three and four of this document that are for completion by the healthcare officer and locating officer, have not been completed. He was allocated to cell E4-07, a double occupancy cell in the first night centre in E-Wing.

I spoke with prisoners who had been accommodated in E-Wing that night. One of these prisoners was Prisoner A who said that he worked in the wing as an 'Insider'. He explained that the role of the Insider was to spot vulnerable prisoners and, having identified a person as vulnerable, to report this to an officer. He said that he had known the man for a couple of years from times in prison together and they were friends. He said that the man was 'a bit messed up' because of his problem with drugs, but it was a problem that he wanted to address.

Prisoner A spoke with the man on the evening of 22 October: *'Yeah I actually seen him and spoke to him and he was pretty depressed at the time, fed up, so with him he normally puts himself on [an F2052SH], he's known for that and for the attention ... because obviously some of the officers in this jail don't give you the attention that you should get so he puts himself on [an F2052SH] and more or less gets the attention that he needs.'* I asked Prisoner A if in doing this it was the man's intention to harm himself or if it was simply to manipulate the system. He replied: *'Not necessarily wanting to harm himself, no I wouldn't put him as in that category.'*

Prisoner A did not speak to staff about the man. He said: *'... everyone is a bit down, we have our days you know what I mean, but I had no idea that [he] would have things on his mind like that, like what happened ... I didn't expect nothing like that at all ... if he had anything important to say, you know, he was feeling a bit suicidal or a little bit depressed or whatever and ... how do I go about doing whatever, I would have ... mentioned it to an officer.'*

Prisoner B, who was also an Insider, said that he had not previously known the man, but they had had a five to ten minute conversation on 22 October. He had seemed fine.

Prisoner C was a prisoner who worked as a 'Listener' and who made himself available in E-Wing to meet prisoners returning from court who might need help. On 22 October, he went to speak with the man: *'I went to him and ... [asked how he was doing] and to me he looked really, really distressed ... but he didn't want my help, he didn't want any kind of a thing, he just said he is okay ... he just wanted to go back to his cell ... I [talked] to him about two or three minutes and he won't actually ... give me any output at all ... he just wanted to go, I just want to go back to my cell, and I told the officer ... I said I am worried about ... this guy he looks really, really worried and he looks distressed could you please look after him and the officer said fine no problem.'*

I then spoke to [a Senior Officer] and at the same time I spoke to the governor there because I was really concerned about [him] and that is all I could do ... I have never seen anybody in that way since I have been going over there ... you will see people crying, you will see people in distress but they will come out with some kind of talk and they would want some kind of sympathy but this guy was too ... too cooped up for himself.'

I made enquiries with the members of staff who had been on duty during the evening of 22 October. The only member of staff who could recall anything of note about the man that evening was SO B. He said: *'I recall that ... between roughly twenty past eight and maybe quarter to nine I went onto A-Wing ... I met up with ... I believe ... the Governor and ... I believe ... the PO ... there was a bit of concern about [his] drugs and the medication that he required and ... [he] was concerned that he wasn't getting his medication [but the problem] was resolved ... [and he and the other inmates were taken off to E-Wing].'* I asked SO B if any prisoner had raised concerns about him. He replied: *'No. No inmate actually raised any concerns with me directly or indirectly during that evening.'*

The man made two telephone calls on the evening of 22 October. One was to a female friend, whom I believe to have been his girlfriend. The second call was to his mother. The call to his friend was made at 7.55pm. She was clearly unhappy about things she believed were being said about her and it also seems that he had assaulted her. Part of the conversation included him saying: *'I'm in here for breach of bail like because I was going round and seeing you. I'm not in here for the assault ... Listen I'm not going to get through this ... I want to say goodbye to you right ... You're not going to be hit any more because I won't be around, you know. I can't take this no more ... Just try and remember me for the good things, I mean if there is anything, I've got to go alright.'*

At 8.11pm the man telephoned his mother and told her that he had spoken to his friend and he said: *'She's got ... to say that she's willingly seeing me so ... give the police a bell ... to tell them that we was willingly seeing each other ... I've got someone to try and bring her round to that. So if you could phone her up and tell her that ... has phoned me up.'*

Saturday 23 October 2004

The man was invited to attend an induction interview by Officer C. He refused this invitation but he was issued an induction pack containing information about the prison regime and was given a postage free envelope to send a letter.

He was assessed by Nurse A from the detoxification team. The nurse said: *'I assessed [him] thoroughly [he gave] me a history of ... drugs and he didn't show any sort of mental health problem, any self-harm history, any suicidal thoughts ... after that I ... done his urine test and after his whole assessment I discussed my caseload with my doctor and then we prescribed the medication.'*

Prison Doctor A confirmed that he authorised the man's prescription which Nurse A had presented to him.

Prisoner D was a prisoner who knew the man from his previous sentence. They did not physically meet while the man was back at Pentonville this time, but while on exercise the man had shouted to him from E-Wing. Prisoner D was unsure about the day, but believed it must have been Saturday 23 October. The man asked him why he was back in prison and he asked the man the same question. Prisoner D said at interview: *'I couldn't really hear what he was saying. But ... he seemed okay at the time ... we both had a laugh and then I said alright I've got to go, I'll see you soon and that's the last I spoke to him or heard of him ... He seemed ... like his normal self yeah, he seemed like as I know him he's sort of like he's happy-go-lucky, that's how I know him, he's like he'll be alright one minute, he'll be sort of like laughing, joking then he might have a serious side to him where he's like, look I've got the hump ... just leave me alone and I'd be alright, no problem ... but if you need someone to talk I'm here and he's like okay, no problem. Sometimes he spoke to me, sometimes he never. It's just prison.'*

Prisoner D then offered his opinion of what he felt had happened. He said: *'... he's realised he's back in prison, it's like a downfall cos he's in and out, in and out, in and out, in and out, it's like a downfall, I think what he's done this time is thought okay let me try and get my head together, get over the hospital and try and work it. So what he's done is he's tied himself up with a noose and it's gone wrong ... he hasn't meant to do that but he's done it and it went wrong and it happened ... What I mean by that is ... certain people will come to the prison and say they're depressed or suicidal or something like that to get them to the hospital wing. At first, when you first come to the prison, there's not a lot of people on the hospital wing, it's like slow, it's relaxed. You can see your doctors every day, you can speak to the doctors and get different medication off of them, you can get sleeping tablets cos you're not sleeping, you can get this off them, you can get Valium of them ... and it helps you get through the first few weeks of coming to prison. So that's what I reckon he's tried to do.'*

He continued: *'What people do is normally they've got cellmates and they'll tie it round their neck, tie it round the bars and say like press the button ... so the light will come on and then come and hold me and when the officers come ... say you were sleeping and [woke and] quickly grabbed [me] ... Then the boy gets taken to the hospital and he gets put in a strip cell ... so it gets him to calm down and then he gets thinking and then he decides like I want this off the doctor, I want that, I'm going to try for this or I'm going to try for that. That's, I ain't being funny but that is how it happens in prison, that is what people actually do, I know it's hard but that is what people actually do in prisons.'*

I checked Prisoner D's cell movement history and locations against the allocated exercise yards that he would have used. None of the locations recorded would have placed him in B-yard, the only exercise yard where he could have spoken to prisoners in E-Wing. However, he was very insistent that he had spoken to the man during this period.

Prisoner E said that he had known the man for about 15 years. Like Prisoner D, he also described him as happy-go-lucky with some low moments. He had seen the man on both Friday and Saturday when he seemed very despondent, saying on Saturday morning that he was having a bad day. Prisoner E did not inform staff that he was concerned about him. He saw him again on Saturday afternoon when the man asked for something to read. He said that he did not think that the man had intended to take his life.

Little else is known of the man's actions on Saturday. Prisoner A said that he had seen him in the wing and they had exchanged hellos. The man was chatting to other prisoners at the time.

Sunday 24 October 2004

At interview, Nurse A said that the man would have had for a follow-up review on the afternoon of 24 October to check how he was coping with detoxification: *'... when I went ... to the wing I saw ... [him] in front of his cell, he was drinking tea ... I [said] hello ... and [asked] him, how's you coping with the treatment? And he said I'm very happy with the treatment plan, I don't have any problem with the treatment. I said to him ... I'll come [this] afternoon, I will review your details ... check [your] blood pressure ... and everything.'*

Officer B was on duty in E-Wing on 24 October. He had not previously met the man but met him that day because his cellmate was to be moved to another cell: *'The Polish prisoner who was in with [him] ... couldn't speak English and he was getting ever so upset so ... we had to try and find someone who could speak Polish ... So we did that and moved him over just before lunch, went in there, sort of managed to explain to him what we was doing and [he] was laying in his bed and I [asked if he was] alright. He said: "Yeah I'm alright Gov." [I said to him that] we'll sort out after dinner what's happening [about finding a new cellmate].'*

Officer B said that Pentonville's regime on Sundays comprised church services in the morning, after which staff would deal with any problems prisoners might have. Lunch would be served at midday and in the afternoon prisoners would go to exercise followed by association. Officer B spoke to the man at lunchtime and asked him if he was okay given that he had lost his cellmate. He replied that he was fine.

Just after prisoners had been locked into their cells after collecting their lunch, Officer D responded to the man banging on his cell door to attract her attention. He said that he needed some sugar for his tea and that another prisoner had promised to give him some. The officer let him out of his cell so he could collect the sugar and she then locked him back into his cell. She said that his demeanour had given her no cause for concern. After this, she went to lunch.

Lunch Patrol of A and E-Wings

At weekends, A and E-Wings are staffed by the same group of officers. The majority of officers work in A-Wing. Two officers work in the much smaller E-Wing. I interviewed Officer E, an officer who normally works in A-Wing. He said that on both Saturday and Sunday, 23 and 24 October, there had been no substantive Senior Officer on duty in the wing. The Governor asked him to assume the senior officer's duties and he agreed to do so.

On Sunday 24 October, there were just ten officers on duty, which was the minimum staffing level for the group. This meant that there was no spare officer to cover the lunch patrol period. Officer E asked for a volunteer to forego their lunch break and Officer A agreed to do so on the understanding that he would leave the prison an hour before the normal end of his shift.

One of the duties Officer A would carry out during the lunch patrol was to supervise the A-Wing cleaners as they collected the clean laundry (the kit change) for A-Wing. This was a task usually carried out during the lunch period on Saturdays, but a technical hitch meant that this weekend the kit change had been one day late. Officer E had only worked in A-Wing for ten months, but throughout that time it had been the practice to let out cleaners during the lunchtime patrol state when they would carry out work under the supervision of the lunch patrol officer. He said that this was also the practice in other wings. As far as he knew, management were not made aware that prisoners were out of their cells during the lunch period.

Officer E said that on 24 October there would have been two or three prisoners out of their cells working during the lunch period. As these prisoners were cleaners, they could be expected to work unsupervised to a certain extent, allowing Officer A to carry out his responsibility for patrolling A and E-Wings.

Officer A confirmed that he had unlocked three of the A-Wing prisoners at lunchtime to assist with the kit change. Officer E had authorised him to do this. Officer A said that he was mainly based on the 2's landing that lunchtime, from where he was able to see the cell bell panel (which illuminates if a prisoner presses his cell bell button). He said that he had answered cell bells from A-Wing during this period. However, no lights came on for any cells in E-Wing so he had not visited that wing at all.

In Pentonville, the 2's landing is the ground floor landing, the 3's is the first floor, the 4's is the second floor and the 5's is the third and top floor.

Principal Officer (PO) A, who had been the Orderly Officer on 24 October, said that he was unaware that prisoners in A-Wing had been unlocked that lunchtime. He added, however, that as a matter of custom and practise, several wings within Pentonville did allow prisoners out of their cells at lunchtime to carry out work. No formal system was followed for obtaining managerial authorisation for this to be permitted.

The communications log contained no entry that prisoners had been let out of their cells that lunchtime. I found this to be of great concern, especially as PO A is Pentonville's security department manager.

Return to Afternoon Duty

Staff returned from their lunch break at about 1.45pm and Officer E held a briefing meeting with all of the officers. After the briefing, Officer A went with Officer B to E-Wing, where they unlocked the cleaners. Officer B then went to the wing office to sort out prisoners' mail.

At interview, Officer A said that after lunch he had taken one of the cleaners to A-Wing to collect E-Wing's kit. On his return to E-Wing, he went to the 3's landing to answer a couple of prisoner calls – he could not remember whether it was before or after collecting E-Wing's kit that he first noticed that lights were illuminated on the call bell panel.

After Officer A had dealt with those calls, the cleaners asked him if they could play backgammon. As there was no other work to be done, he allowed them to play and he had asked how the game was played. They were playing on the pool table which is situated close to the cell bell panel. From where he was standing, he could check whether any lights illuminated while also observing the game of backgammon. He denied that he had participated in the game, although he had moved some pieces in asking about whether certain moves were allowed.

I interviewed Prisoner B, a cleaner in E-Wing. He said that he was unlocked by Officer A at 2pm. The other cleaners were playing backgammon and Officer A had also played a game.

One of the cleaners, Prisoner F, said: *'Approximately 2pm in the afternoon I was let out along with the other cleaners on E-Wing ... [Prisoner G, another of the cleaners, and I were] playing backgammon ... [Officer B] ... and [Officer A were] on duty. Both these officers seemed intrigued by the game and wanted to know the rules ... [Officer A] was starting to know the rules of the game and he wanted to try his luck. I was playing with [Officer A] [and] it came to my notice that a red light was on [on the cell bell panel] I can't remember if I noticed it straight away when I came out my cell or ... later on ... [All] of us cleaners we take it upon ourselves ... if an officer isn't on the ground floor for some reason [or it] very often happens ... that the inmate will be ... asked by a member of staff [to] see what the problem is ... cos they can't be at two places at once. But anyway I was playing backgammon and showing the rules to [Officer A] ...'*

Prisoner A said that Officer A unlocked him, along with the other cleaners in E-Wing, at about 2.10pm. His cell was opposite the wing office and directly opposite the cell bell panel. He noticed on coming out of his cell that lights on the panel were illuminated. He said: *'[Some of the cleaners started to play backgammon] and [Officer A] was ... either playing or watching a game. I*

heard him say that he would like to learn how to play the game ... but anyway then [Prisoner B] was like talking and whatever and after that we just done our own thing and I went back into the cell, come back out ... and we was carrying on talking ... the backgammon [game] finished and I heard [Officer A] say to one of the cleaners would you go up and see the bells, answer the bells ... [Prisoner G] went up to ... to check the lights, two minutes after I heard, oh God ... quick, quick, I can't believe it, Governor quick up here and ... Officer A run up to the ... the 5's ...'

Prisoner A said that the lights to which Officer A had referred, were the same lights that were illuminated when he was unlocked at 2.10pm. He also said that, from the point of being unlocked to the time that the man was found, he had not observed Officer A leave the 2's landing to go to the landings above.

Prisoner H, another cleaner in E-Wing whose cell was opposite the office and cell bell panel, said that the cell bell lights were not illuminated when he was unlocked. He would have noticed if they had been illuminated, as his practice was to check whether any prisoners had pressed their bell as they often did if they wanted some water. During his interview, he made no mention of seeing a game of backgammon being played.

Prisoner G confirmed at interview that he was a cleaner in E-Wing. He had not looked at the cell bell panel when he was unlocked so could not say if it had been illuminated at that time. He said that he had played a game of backgammon with one of the other cleaners and the officers were watching the game as they were walking around carrying out their duties. He lost his game and so he went to the 3's landing to give a prisoner a cigarette paper, as he had promised to do earlier that day.

The Discovery of the man in his Cell

Having taken a cigarette paper to a prisoner on the 3's landing, Prisoner G walked back down the stairs and as he did so he looked to see if any of the lights on the alarm panel were illuminated. He said: *'Since I got the job [as a cleaner, officers] sort of suggest to me that ... if you are up there, just answer the light, well not answer it, just say [to the prisoner] what do you want and then you just relay the message back to the officers ... not that [it] is my responsibility ... it is just something that you do ...'* He saw that someone from the 5's landing had pressed their call button so he made his way to the cell and opened the cell door observation flap to look inside: *'[At first] I just thought he was just standing at the back ... he was standing at the back wall, erm took me about 10 seconds what was going on, then I just probably, I made a bit of a scream I suppose ... then called the officers.'*

Officers A and B said that they heard Prisoner G call for assistance and they responded immediately. The time was just before 2.30pm. Officer A looked through the observation window and saw the man hanging by a ligature. He was dressed only in boxer shorts. Officers A and B entered the cell. Officer A supported the man's body while Officer B released the end of the ligature from

the window frame. The man had used his belt as a ligature, trapping the tail end of the belt in the window. Officer A said that his complexion was quite pale and his lips were cold and slightly blue. After laying him on the floor, Officer A loosened the ligature and, on finding that he was not breathing, he commenced attempts to resuscitate using both mouth-to-mouth breathing and chest compressions. In attempting resuscitation, he was helped first by one of the prisoners, Prisoner H, before the prisoner was relieved by Officer F. Officers A and F continued with their attempts until relieved by healthcare staff.

As Officer A started attempts at resuscitation, Officer B tried to radio for assistance. Unable to obtain clear reception from the 5's landing, he ran down to the 2's landing where reception would be better. From there, he radioed for a level one medical emergency to be issued. In the meantime, Officer B had accepted an offer of help from Prisoner H.

Prisoner H confirmed at interview that he was trained in first aid and the officers accepted his offer of help. He checked the man's neck and groin for a pulse but found none. He loosened the ligature and started giving heart massage while Officer A gave mouth-to-mouth. He and Officer A continued with their efforts, stopping at intervals to check for signs of a response but none were detected. He said that the man's body had already started to turn cold. He surmised that he had hung himself 15 to 20 minutes earlier as his shorts, which had been wetted when he had urinated, had already started to dry. Throughout the time he was helping, he believed that the man was already dead.

Officer F said at interview that he was told by Officer B that a prisoner had been found hanging on the 5's landing. He had immediately gone to help. He took over from Prisoner H in carrying out chest compressions while Officer A continued giving mouth-to-mouth. He said that when he put his hands on the man, his body was cold and his toes were turning blue or black in colour. After being relieved by medical staff, he played no further part.

Charge Nurse B was the first medical person to attend. As he arrived, the man was on the floor and officers were trying to undo the belt around his neck. It was a woven leather belt and was very tight. He used his anti-ligature knife to cut the belt and it sprang apart. He commenced attempts at resuscitation and then two further healthcare staff, Healthcare Officer B and Nursing Sister A, arrived. Nurse B said that he gave mouth-to-mouth, HCO B gave chest compressions and Sister A monitored for vital signs. The nurse said that at first he gave mouth-to-mouth without the use of a mouth-to-mouth shield (a mouth-to-mouth shield has a one way valve and provides a barrier between the person giving aid and the patient). Later on, an officer had given him a mouth-to-mouth shield. The nurse described the man as very pale, cold to the touch and his pupils were dilated. They continued with attempts to resuscitate until the paramedics arrived.

HCO B said that when he received the radio call asking him to attend E-5, he and Sister A collected emergency equipment, including an oxygen bottle and mask, and they went to E-5. On entering the cell Nurse B was there attempting resuscitation. HCO B said that the three of them continued to try to resuscitate

the man until the paramedics arrived and took over, which was at approximately 2.46pm.

Sister A said that, when she attended the incident call with HCO B, she had checked the man for vital signs. She found that he had no blood pressure, no carotid pulse, no radial pulse, no femoral pulse and no pedal pulses. His pupils were dilated, his peripheries were turning blue and his body was cold. While Nurse B and HCO B were attempting cardiac and respiratory resuscitation, she continued to monitor the man and kept updating her colleagues. When the paramedics arrived, they took over and the doctor in the team gave the man adrenalin. They began to take him to the ambulance and, as they went down each flight of stairs, they stopped to make a further attempt at resuscitation. Eventually, however, the doctor asked if all were in agreement that resuscitation should cease, after which he declared that life was extinct.

Sister A said that the emergency bag taken to the scene contained a defibrillator, but she was not trained to use one and she was not sure if the other nurses present were trained either. She confirmed what Prisoner H had said about the man having passed urine which had begun to dry.

I was curious why Pentonville's own doctor did not attend the incident. The duty doctor was Prisoner Doctor A who was recorded as leaving Pentonville at 2.40pm – some ten minutes after the incident began. The doctor said that he completed his duties at about 2.35pm and had then left the prison. Although he remained on-call, he was not contacted.

Other Persons Attending the Scene

PO B and PO A responded to the alarm. PO B said that when he arrived at the scene he saw Officer A attempting resuscitation assisted by a prisoner, Prisoner H. He issued a level one emergency, as he wanted healthcare staff, including a doctor, to attend. He also requested that an ambulance be called.

The governor-in-charge arrived as did the duty Governor. PO B briefed the two senior governors, after which the governor-in-charge opened the command suite with PO A. The duty governor and PO B took responsibility for management at the scene and ensured that staff were sent to escort the paramedics upon their arrival. In due course, they arranged for the cell to be sealed, for statements to be taken from witnesses, and for the welfare needs of all those directly involved to be met.

Immediate Action Taken Following the man's Death

The governor opened the command suite and followed the contingency orders for dealing with deaths in custody. The Prison Service's National Operations Unit and press office were notified. The local police agreed to visit the man's family to break the news to them in person.

The cell was sealed and a 'cell seal log' commenced as soon as was practicable.

The governor called together as many as possible of the available staff who had been directly involved for a hot-debrief. Staff discussed the events themselves, staff needs in terms of care and welfare, and prisoners' needs bearing in mind that they would be upset, angry, confused, and in need of information. The governor said that he felt that staff were grateful to have had the chance of taking part in the debrief.

Staff were asked to make statements about their individual actions and evidence was also obtained from the prisoners who had been involved.

SO A, Pentonville's suicide prevention officer, arranged for all prisoners who had had direct involvement to see the doctor and any who seemed to have been particularly badly affected were made subject to close observation (F2052SH procedures). He also arranged for prisoners involved to be allowed free telephone calls so they could contact their families and they were also allocated an additional visiting order.

An instruction was sent to the wing managers that all prisoners who were already on open F2052SHs should be spoken to and their circumstances reviewed. SO A visited the wings and made random checks to ensure that the instruction was carried out.

A notice to prisoners and staff informing them of the man's death was published throughout the prison.

Contact with the man's family

Pentonville arranged for the police to visit the man's mother to inform her of his death. At 45 minutes after midnight, the mother's friend telephoned the prison to say that the family had only just heard from the police about the death and he wanted more information. As no senior staff were in the prison at that time, he was asked to ring back at 8.30am.

The governor acted as Pentonville's Family Liaison Officer. At interview, he accepted that initial contact with the family was unsatisfactory. He knew that it was after midnight that the police had finally visited the man's mother, but he did not know why the visit was made so late.

He subsequently met the man's mother and her partner twice when they came into the prison. He spoke with them by telephone on a number of other occasions and he also wrote to them.

The Church of England chaplain met the man's mother and her partner when they visited Pentonville on 25 October. He met them again the following week because she had wanted to visit the cell. The man's funeral took place on 9 November and, because his death seemed to have had such a very big impact in the prison, the chaplain arranged to conduct a service in the prison chapel to coincide with the funeral.

Cell Bell Alarm System

Photographs of cell bell alarm panels are contained in the appendices.

The E-Wing cell bell light panel is positioned to the right of the wing office as viewed from A-2 landing. The panel has eight lights, two for each of the four landings, one light for the left side of the landing and one for the right side. The panel has a speaker, a lamp test button and a mute button. When a cell bell button is pressed, an audible alarm sounds and the cell location is identified through a light on the alarm panel illuminating for the relevant half landing. A light outside the cell itself also illuminates. When the mute button on the alarm panel is pressed, the audible alarm stops. However, the light on the alarm panel remains illuminated until a button outside of the cell is pressed. On checking the panel, I discovered that there was evidence that tape had been placed across this mute button to prevent the audible alarm from sounding.

I asked staff if they had ever heard the audible alarm sound from this panel. Officer A said that he had never heard the alarm sounding. He confirmed that he had seen tape placed over the panel's mute button but said that he had not placed the tape there.

I asked various prisoners from E-Wing whether they were aware that tape had been used to keep the mute button permanently depressed. Most were aware that that was the case, stating that the panel had been in that condition for a number of months.

Officer E, the acting Senior Officer on 24 October, said that he had not often worked on E-Wing and had not noticed the tape when he attended the wing that day. When he next went to work, he believed on 25 October, he had been detailed to E-Wing as the prison had wanted some experienced staff to be on duty. He had seen the tape then and had removed it.

A further cell bell panel is located on A-2 landing. This panel has lights for both A and E-Wings, once again with one light for each half landing. This panel is also fitted with a speaker, a lamp test button and a mute button. I was advised by the prison's works department that a panel light should illuminate and the alarm should sound when any cell bell was pressed in either A or E-Wing. This is in addition to the panel in E-Wing being activated. On inspecting this alarm panel, I saw that the speaker had been covered with adhesive tape and the mute button was missing. I tested the system by pressing a cell bell button in E-Wing. Although the light on the panel illuminated, no audible alarm sounded.

I spoke with a number of officers who regularly worked in A-Wing and was told that the audible alarm on the A-Wing panel had not worked for some time. One Senior Officer, who had worked in the wing for quite a period of time, said that she had not realised that the panel had an audible alarm.

PO C, the manager of A and E-Wings, said that the wing maintenance checks carried out by his staff did not include checks of areas outside of cells, such as communal areas, cell bell panels etc. I showed him the photographs of the

alarm panels and asked him to comment. He admitted that the panels had not been checked. He said that he knew the lights worked, but he had never heard the alarm panels make any noise. He said that the senior officers would say the same. One of his senior officers, who had worked in the wing for 18 months, had told him that she could not recall hearing an audible tone from either alarm panel in all that time.

I informed Pentonville's governing Governor about what I had discovered. I noted during the course of this inquiry that work had been carried out on the cell bell alarm system but, not having carried out a further test of my own, I am unaware if the problems have been resolved.

Conclusions

Discharge from Pentonville at End of Previous Sentence

It is apparent, from the interviews conducted and the documentation obtained, that the man received a great deal of support both during his previous sentence and for his return into the community. The actions of his key worker in obtaining a placement at a drugs rehabilitation centre and his intention to escort him there on release from Pentonville were a genuine attempt to aid him in his fight against drug addiction.

Having attended court on 7 October, it is unfortunate that the man was taken to HMP Wormwood Scrubs for the night instead of returning to Pentonville as the key worker had arranged to meet him there on 8 October to accompany him to the rehabilitation centre. Unfortunately, current prison population pressures can make it impractical to arrange for a prisoner to return to the same prison following a temporary absence from that prison. Of course, the key worker's presence was not essential to the man's admission to the rehabilitation centre and it was his own decision not to go directly there after leaving Wormwood Scrubs.

Reception to Prison and Events Leading up to the man's death in October 2004

The man was received into Pentonville on Friday 22 October. He received a health-screening interview during which he declared his drug dependency to healthcare staff. Although his PER form indicated that there were warnings for self-harm/suicide, this appears not to have been noted and he said that he had no history of self-harm and no such thoughts that day. It would appear that he received appropriate medical treatment to address his detoxification needs. He went through the reception process with no issues of concern being identified in respect of his mental health condition by any of the personnel who had contact with him.

A cell-share risk assessment indicated that there was no reason why he should not be located with other prisoners, and he was located in the first night centre in a double occupancy cell.

I am of the opinion that reception procedures were conducted correctly with staff fully carrying out their obligations to address any issues raised or identified at that time.

He was observed by some of the prisoners in the first night centre to be in a depressed state or mood and one prisoner said that he mentioned this to staff. SO B recalled only that the man had been concerned about his medication and that, once he had seen the doctor his concerns were resolved. Prisoners who had known him previously said that, although he was generally 'happy go lucky', his mood would often change to being serious.

In the telephone call that the man made to his girlfriend, he indicated that he felt unable to deal with his return to prison and that she should remember him. He said that his return to prison was for a failure to abide by his bail conditions and intimated that it was through staying with or visiting her that he had breached his conditions.

In the call to his mother, the man asked her to inform the police that his girlfriend was seeing him willingly and he added that he had arranged for someone to try to persuade her to agree to this. He was due to return to court on 29 October and he referred to this date in his conversation with his mother.

Although his conversation with his girlfriend could be taken as notice of intent to self-harm or to take his life, the telephone call to his mother shows that he was thinking about his future court appearance. I am of the opinion that he felt somewhat down at that time having returned to prison after such a short period. However, this would be a natural reaction and I do not believe that he had thoughts of self-harm or suicidal ideation at that point in time and had certainly said nothing to staff to suggest that might be the case. I am therefore of the view that he was assessed and accommodated appropriately that night.

Saturday 23 October 2004

I am satisfied that the man was identified and offered his full prisoner induction package/interview and that it was through his own choice that he refused to become involved in this process. From other investigations, I understand that it is not unusual for people who are familiar with prison systems to turn down the option of an induction interview.

The man was assessed by Nurse A from the detoxification team and he wrote a prescription for his detoxification medication. The duty doctor authorised the prescription but without examining him himself. The doctor's failure in this regard was considered by the clinical reviewer to be poor practice.

Because of the limited information about the man's interaction with staff and prisoners on Saturday, it is impossible to gauge his mood and feelings that day. However, the absence of any incident report or observation by staff indicates that he did not approach staff with any problems.

Sunday 24 October 2004

Nurse A said that he saw the man on Sunday morning. He appeared to be well and said that he was happy with his treatment programme. He was due to be seen in the afternoon for a full assessment.

A number of prisoners were moved from their original cells to allow prisoners who could not speak English to move in with others who could speak their native tongues. I consider this to be good practice. However, this resulted in the man losing his cellmate and being left alone in his cell for the lunch period. While this was not desirable, it was not contrary to any instruction or order applicable to the first night centre. Staff told him that they would deal with the issue after lunch and he raised no objections. He had been in custody for two days by this time and had given no indication to staff that he might have any thoughts of self-harm. There was nothing to suggest that leaving him in the cell on his own would change this situation. I am therefore of the opinion that the staff should not be criticised for their actions.

The Lunch Patrol of A and E-Wings

Because of staff shortages, Officer A volunteered to work through his lunch break and to go home early in recompense. This would result in him working from 8am to 4pm without a lunch break. This is not good practice and is contrary to European employment law.

I have been unable to find any written instructions about staff duties during the lunchtime patrol period. One would presume that, as the task is called lunch patrol, the officer is required to patrol their areas of responsibility and not just answer cell bells as was stated by Officer A.

The Prison Service's definition of patrol state indicates that all prisoners should be secured in their cells. This is especially important as only one officer is allocated to patrol each wing, and it is unsafe from both a security and a health and safety perspective for prisoners to be out of their cells at this time.

I was deeply concerned when told, and then having observed for myself, that prisoners were regularly unlocked during this period while under the supervision of a single officer. I observed this not only in A and E-Wings, but also in other wings.

My concern was heightened on discovering that no formal permission was sought from either managers or the Duty Orderly Officer and that Pentonville's communications room was not apprised about what was happening. This, in itself, is a severe breach of prison security.

Cell Bell Light System

The state of the cell bell system is of great concern. The panels in A and E-Wings had both been tampered with and neither had been operating properly for a considerable period of time. I am astounded that there are no system checks or maintenance programmes in place to identify that these panels were faulty.

I also find it inconceivable that the tape on the E-Wing panel remained in place until removed by Officer E 25 October. The tape on the A-Wing panel was still present at the time of my visit.

The absence of the audible alarms in both panels in effect meant that the patrol officer would only have been aware that a prisoner had pressed his cell bell by looking at the panel. Officer A was in A-Wing throughout the whole lunch period supervising a work party of prisoners making up kit changes.

From the evidence about the man's condition when found, I am of the opinion that Officer A either failed to look at the cell bell panel at all or, if he did so, that he failed to respond to the cell bell light.

I am concerned to learn that it was common practice not only in A and E-Wings, but also elsewhere in Pentonville, for officers to ask prisoners to answer cell bell lights. This is unacceptable and diminishes the value and purpose of a cell bell call. It also fosters complacency among officers that many of the calls are activated by prisoners seeking minimal services such as newspapers, lights for cigarettes, etc.

Return to Afternoon Duty

On the return from lunch of staff, the wing held its normal afternoon briefing meeting. While it is commendable that staff are apprised and regularly briefed, I pose the question as to which officer, if any, was patrolling the wing during this meeting. I found no evidence to identify who carried out this task.

Officers A and B returned to E-Wing and unlocked the cleaners who started to play backgammon. It is of note that a number of prisoners stated that, upon leaving their cells, they observed cell bell lights illuminated on the alarm panel. Officer B went to the wing office to deal with prisoners' mail and Officer A said that he answered cell calls. Both Officers at one stage or another agree that they looked with interest at the game of backgammon that the prisoners were playing. Some of the prisoners said that Officer A actually played a game of backgammon. If this is correct, then it casts doubt on his claim that he had answered cell calls at around this time as he reported he did and as he was, indeed, required to do.

The Discovery of the man in Cell

Although Officer A said that he had not asked him to do so, Prisoner G answered the man's cell bell call and on looking into the cell saw him hanging. He called to staff and Officers A and B responded immediately. They entered the cell and removed the ligature from its fixing point. I am confident that the Officers' response was immediate and appropriate and, having entered the cell,

they carried out the correct procedure for dealing with a person found suspended by a ligature.

Officer B left the cell to request further assistance and having difficulty in gaining a clear transmission, moved to an appropriate location where he could transmit and receive clearly. It is commendable that Prisoner H attended the scene and, having been trained in first aid, actively assisted Officer A in attempting to resuscitate the man. I do not consider there to be any issue with Officer B leaving Prisoner H and Officer A to continue without his presence.

Discipline and medical staff responded to the alarm call and attended the scene without delay. Although both Officer A and Prisoner H said that they loosened the ligature around the man's neck, it was Charge Nurse B, the first medical person to arrive, who cut away the ligature using an anti-ligature knife. He commenced attempts to resuscitate and was quickly joined by other medical staff who brought emergency equipment. Staff continued with their efforts to resuscitate until the arrival of the paramedics who took over from them.

I am confident that Pentonville's medical response to the incident was extremely quick and appropriate. Healthcare staff took control of efforts to resuscitate immediately upon arrival at the scene and worked extremely hard in their attempts to revive the man. I am concerned, however, that the healthcare staff had not been trained in the use of a defibrillator. There seems little point in deploying this equipment if it cannot be used.

I am also concerned that the prison doctor is recorded as having left the prison at 2.40pm, which was some ten minutes after the man was found. Personnel in the gate lodge must have been aware that a level one medical alarm was in progress and I am therefore surprised that they did not advise the doctor of this fact so that he could attend. That said, the absence of the doctor probably did not diminish either the level of medical intervention or the standard of resuscitation administered to the man.

The ambulance service was contacted on the instruction of PO B. Their arrival on scene was extremely quick and the additional arrival of paramedics from the London Air Ambulance Service was also quick and unimpeded. It was quite appropriate that, upon their arrival, these personnel took control of the man's further treatment.

It is worthy of note that two prisoners and one of the medical staff who attended the scene observed that the man had passed urine and that the affected area had partially dried. This, in addition to descriptions of his body, would suggest that he had been dead for some time when found. Charge Nurse B echoed this opinion when questioned during interview. I reject Officer A's claim that he had answered all cell bell calls during the lunch time period and on his return to E-Wing after lunch.

It was of interest to hear from two prisoners who knew the man that he was known to place himself on the F2052SH monitoring system. Indeed, Prisoner D's theory as to the reasons why prisoners carry out this action and the

methods used to fabricate an attempted hanging are extremely alarming. One cannot help but draw similarities with the incident under report, with the possibility existing that this might have been an attempt to manipulate a move to the hospital wing that went tragically wrong.

The man must have first pressed the bell by his cell door before going to the back of his cell, ten feet away, to put the ligature around his neck. This indicates that he expected someone to answer his call. The cell call light outside his cell and the lights on both A and E-Wing alarm panels would all have illuminated when he pressed the bell. This means that these lights were illuminated for a longer period than Officer A's evidence would suggest.

The police officer dealing with this case said that he was advised after the post mortem that, due to the material used for the ligature, death would have occurred quite quickly. The information from the police suggests that it might not have been possible for the man to be saved even with rapid medical intervention, but that is something we shall never know.

Management of the scene

Sufficient and appropriate managerial staff attended the incident and managed the scene. I was pleased to note that a log recording the events of the incident was initiated at an early stage at the scene and that this remained active until the completion of the incident. I am of the opinion that the incident scene was effectively managed and that all the requirements of both Prison Service Orders and preservation of evidence were fully followed.

Immediate Action Taken by Establishment

The governor in charge of the prison and the duty governor attended the scene and having completed an assessment and arranged managerial responsibility for the scene, the governor in charge correctly withdrew to open the command suite to initiate the contingency plan for dealing with deaths in custody. A command suite log was maintained throughout the incident.

Management and staff effectively followed the plans: a staff hot-debrief was held, staff care and welfare facilities were provided, reviews were instructed for prisoners subject to F2052SH monitoring and liaison was made with all relevant outside agencies.

I am of the opinion that the incident was effectively managed and that all the requirements of both Prison Service Orders and Pentonville's contingency plans were effectively and fully followed.

Contact with the Family

An agreement was made for the police to visit the man's family to inform them in person about his death. Whilst I can accept that this arrangement was made with the best intentions, I am disappointed that there appears to have been little follow-up contact with either the police or the family on that day to:

- Ensure that the family had been advised of his death.
- To answer questions about the circumstances of his death and the investigation processes that would then follow.
- To provide personal contact with a named family liaison officer from the prison.

Initial contact was not made until the early hours of 25 October. Naturally, the man's family wanted to speak with someone from Pentonville who could give them more information. While the officer answering the man's mother's partner's telephone call was correct in not offering uninformed information, I am surprised that management did not leave instructions as to what information should be passed to the family in the event that they should make contact. It should not have been a surprise that, not having been contacted prior to the end of the day, the family would make contact at some stage.

The reported contact with the man's family after this date appears to have been managed well. I have received no information to the contrary.

Clinical Review

I concur with the conclusions reached by the clinical reviewer.

Level of Compliance with Authorised Procedures

Pentonville was found to have a comprehensive suicide prevention policy document which, in the main was found to be compliant with current Prison Service directives and requirements.

The systems outlined in the suicide prevention policy for the monitoring of F2052SH documentation were good and again fully compliant with the requirements of Prison Service directives and requirements.

Contingency orders were found to be in place in Pentonville covering incidents of hanging and the sudden death of prisoners in custody. These were comprehensive and fully compliant with Prison Service orders.

An emergency medical response protocol was in place to address all medical emergency situations. All staff spoken to had a sound knowledge of the system and were confident in its use.

Recommendations

The following recommendations were made in the draft version of the report. The Prison Service's response is included in italics following each recommendation:

1. The Governor should commission an inquiry into the apparent regular breaches of security caused through the unlocking of prisoners during patrol state without notification to either the prison's communications room or duty managers.

Recommendation partially accepted: There have been incidents where in patrol state prisoners have been unlocked without staff seeking correct authorisation. In each case the incident has been managed according to individual circumstances and outcomes. A Governors order to clarify procedures will be released and the LSS will be updated accordingly.

2. The Governor should commission a review of the process used to identify prisoners who should be prioritised for return to Pentonville following temporary absences in order to prevent recurrence of the problems identified in the man's case which prevented him from being escorted to the drug rehabilitation unit upon discharge on 8 October 2004.

Recommendation accepted: We will commission a review to look at a feasible system of identifying prisoners who should be prioritised for return following temporary absences

3. The Governor should issue an order to his staff instructing them that prisoners located on the first night centre should not be accommodated in a cell on their own and especially if they are the subject of a drug detoxification programme. If for operational reasons they are, consideration should be given as to whether a special watch should be initiated until the situation is rectified.

Recommendation accepted: This is standard practise within the establishment.

4. The Governor should commission a review of staffing levels in A and E-Wings to ensure that there is sufficient managerial (Senior Officer) cover at weekends and to ensure that there is lunch patrol cover without the need for staff to go without a meal break.

Recommendation accepted.

5. The Governor should ensure that the prison's orders/instructions explain the duties of the lunch patrol officer and should ensure that those duties are carried out during the lunch period.

Recommendation accepted.

6. The Governor should commission a review of the means used to check that the cell bell system throughout the prison is fully functional. The current system of reliance on cell fabric checks is clearly inadequate as it failed to identify significant problems with the cell bell system in A and E-Wings.

Recommendation partially accepted: A fully auditable cell call system is currently being installed throughout by Property Services Group. The roll-out is very slow due to population pressures. Until the completion of this system, the Estates department will continue to carry out a weekly test of two cells on every landing [left and right side]. Faults identified are actioned immediately and records kept. If faults are identified on AFC`s, staff can report it straight where they are given a priority timescale.

7. The Governor should commission a review of the reported practice of officers asking prisoners to answer cell calls. The Governor should also ensure that this practice does not recur.

Recommendation accepted: A review is to be undertaken.

8. The Governor should review the prison's policy on responses to serious clinical incidents and, in particular, whether the emergency services should be contacted immediately when a serious clinical incident is discovered.

Recommendation accepted.

9. The Governor should issue instructions to gate staff informing them that in the case of a level one medical emergency being called, the duty doctor should be prevented from leaving the prison until cleared to do so by a senior manager, such as the Orderly Officer or duty Governor.

Recommendation accepted: A Governors Order to be issued and instructions to be incorporated into operating procedures for Orderly Officer and Duty Governor.

10. The Governor should issue instructions about the need to follow-up contact with families in cases of deaths in custody to ensure, if possible, that contact is made on the day the death has occurred. If that does not prove possible, a briefing covering the establishment's approved response should be left with duty personnel remaining in the prison overnight.

Recommendation accepted: There are now four Senior Managers trained as Family Liaison Officers and one Senior Officer. A new FLO strategy is being developed that will ensure that the recommendation is taken into account.

11. The Governor should ensure that all medical staff likely to attend medical emergencies receive sufficient training to operate all equipment carried by them to an incident of this nature.

Recommendation accepted: Training complete and on-going.

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

Recommendation accepted: All operational staff now carry Big Fish knives.

13. The Governor should consider introducing mouth-to-mouth shields as a standard piece of equipment to be carried by all staff who might be involved in attempting to resuscitate prisoners. The Governor should also ensure that all staff are trained in the use of this equipment.

Recommendation partially accepted: All landing offices contain a Safer Custody emergency first aid box which contains this piece of equipment.

14. A letter of commendation should be written to Prisoner H expressing the thanks and appreciation of both the Prison Service in general, and Pentonville in particular, for his personal involvement in assisting in the attempts to revive the man and for the leadership he apparently displayed.

Recommendation partially accepted: The Safer Custody Senior Officer wrote to Prisoner H after the event thanking him for all of his help.

15. The Governor should remind staff in the strongest terms that any tampering with the cell bell alarm system is both potentially illegal and potentially life-threatening and might result in disciplinary action.

Recommendation accepted: A notice to staff went out to this effect and the system was altered to ensure that this could not happen again.

Recommendations on staff performance

The draft report issued to the Prison Service in June 2005 included a recommendation that the Governor should consider commissioning a disciplinary investigation into the actions and conduct of Officer A to address:

- Why he compromised the security of the establishment by unlocking prisoners during a patrol state without authority and without advising the Orderly Officer or Communications room that he had done so.
- Whether he failed to answer the man's cell bell light.
- Whether Officer A was indeed playing backgammon instead of carrying out his duties immediately prior to the alarm being raised by Prisoner G.

In its response to the draft report, the Prison Service informed the Ombudsman that Officer A had resigned from the Service before a disciplinary investigation could be concluded.