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

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

February 2005

This is the report of an investigation into the death of a man, who died whilst a prisoner at HMP Pentonville in June 2005. The man was found hanging in his cell at 5:45am. He was 31 years of age. The toxicology report shows that he had alcohol in his blood.

I wish to offer my sincere sympathy and condolences to the man's family and friends for their sad loss. I know the staff and prisoners at Pentonville who knew him share those sentiments.

Two of my colleagues undertook the investigation, and have been assisted by one of my Family Liaison Officers.

I wish to extend my thanks to the Governor and his staff for their help and cooperation during the investigation. Particular thanks go to the Senior Officer who acted as the local liaison officer. I am also grateful to the Camden Primary Care Trust for instigating a clinical review and the Reviewer for carrying out the review.

The man's death was the second of two such deaths to have occurred at Pentonville within days. The consumption of alcohol is a common feature. The police investigation did not find alcohol in the man's cell. In his case, he was charged with serious offences and was the subject of a probation licence recall. He had been returned to custody on 27 May 2005. He was alone in his cell for the first time on the night of his death.

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PRISONS AND PROBATION OMBUDSMAN **FEBRUARY 2005**

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Summary

1. At 5:45am on a Wednesday in June, the man was discovered hanging in his cell during the early morning roll check at HMP Pentonville. He was alone in a double occupancy cell, and a ligature made from a bedsheet was attached to the window. At the time of his death, the man had been in Pentonville for 20 days.

2. The man was first sentenced to 14 years imprisonment on 27 September 1997. His sentence was varied on appeal to 12 years imprisonment. He was released on licence from HMP Maidstone on 17 May 2004. His licence was due to expire on 17 May 2008.

3. The man appeared at Highbury Corner Magistrates' Court in May 2005 charged with two offences, and was remanded into custody. The Probation Service reported that he had breached the conditions of his licence, and requested that it be revoked.

4. The man went through Pentonville's reception process and was not identified as at immediate risk of self harm. Owing to the nature of his alleged offence, he was correctly identified as a Vulnerable Prisoner and placed on C wing.

5. Staff and prisoners who knew the man stated that he gave no outward indication that he intended to take his life. However, my investigators established from prisoners whom they interviewed that he was fearful of the prospect of a further substantial term of imprisonment.

6. The post mortem toxicology report found the man had a large quantity of alcohol in his blood.

7. This report makes three recommendations.

Investigation Methodology

8. The investigation was opened at the prison on 17 June by my two colleagues. The Governor and his staff produced the man's core file and a number of other documents for examination. The records had been secured after his death.

9. Notices were issued to staff and prisoners informing them of my investigation.

10. Meetings were held with representatives of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB) who both offered their full co-operation with the investigation. Contact was made with the Metropolitan Police who carried out their own inquiries.

11. Documents relating to the man's time in custody were examined. My investigators contacted the coroner's officer, to brief her on the nature and scope of my investigation and request a copy of the post mortem report. They also obtained a copy of the report of the London Probation Area which notified the man's breach of his licence, and requested a review by the Parole Board.

12. Camden Primary Care Trust commissioned a Reviewer to prepare a clinical review of the man's care whilst in prison custody.

13. One of my Family Liaison Officers, has spoken and written to members of the man's family who are aware of nature and scope of my investigation. My Family Liaison Officer has offered to visit members of the family with my investigators. At the time of writing, this offer has not been accepted. To date, the man's family have not voiced any concerns for my investigators to consider but they are keen to be kept informed of my findings.

The Man

14. The man was born on 15 September 1973 and was aged 31 years when he died.

15. He was released on licence from Maidstone prison on 17 May 2004, and was to be supervised by the London Probation Area until 17 May 2008. On release, he was found accommodation in one of the probation area's Approved Premises (hostels). His response to supervision on licence was described as good. He reported regularly and punctually, and complied with the conditions of the licence and the supervision plan. He was undertaking courses aimed to address his offending behaviour, and his feedback was positive. Due to the man's compliance with the licence conditions, he was able to leave the Approved Premises when he secured his own semi-supported housing.

HMP Pentonville

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

17. 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.

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

19. 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 (RAPT) provides drug rehabilitation programmes. Pentonville is represented on the Camden and Islington Drug Action Team.

20. R wing is the Vulnerable Prisoners wing. However, C wing is used as an overspill for R wing. Vulnerable Prisoners who on C wing are unlocked separately from the rest of the prison population and taken to R wing to participate in their activities.

21. On the night of 15 June, the prison held some 1,169 prisoners, of whom 105 were located in C-Wing. Cell C2:14, where the man died, is a double occupancy cell with a metal framed bunk bed. It has in cell sanitation, two small tables and a chair, but does not have in cell electricity.

22. The man was the fifth prisoner to die apparently by their own hand at Pentonville since June 2004. All died within a short period after arriving in custody.

23. Pentonville has worked hard to improve practices since these deaths. The National Offender Management Service's Safer Custody Group has undertaken a review of their procedures and made a number of recommendations. Most of the recommendations have been implemented and there has been a large emphasis on safer custody

led by the Head of Residence. I recognise this much needed improvement. It is also important to note there is still a very long way to go, and resources need to be applied to support the development of a better environment, policies and practices.

Events prior to the man's death

24. The man was sentenced to 14 years imprisonment in September 1997. His sentence was reduced on appeal to 12 years, and he was released on licence from HMP Maidstone on 17 May 2004. His licence was due to expire on 17 May 2008.

25. The man was arrested on Wednesday 25 May 2005, and subsequently charged with two serious offences. He appeared at Highbury Corner Magistrates' Court in May where bail was refused on the following grounds:

    A that he would fail to surrender;
    B would commit offences on bail;
    C the nature and gravity of the offences charged;
    D his previous criminal record; and
    E the likely sentence if found guilty at trial.

26. In addition, the circumstances of his arrest were communicated to the London Probation Area who revoked the man's licence, and issued an order for his emergency recall to prison. After his appearance at court, he was taken to Pentonville.

27. At Pentonville, the man went through the reception procedure. A Healthcare Officer interviewed him as part of his healthcare screen, and completed a healthcare screening form. The man indicated that he had been in Pentonville in 1996, and said that he had not previously attempted to harm himself or felt like harming himself. The healthcare officer recorded on the man's Cell Sharing Risk Assessment (CSRA) form that he was suitable for multi-cell location, and that she had no concerns about him.

28. A reception officer, completed sections one and two of the CSRA, and recorded that the man was of no immediate risk but that his situation would need to be reviewed regularly.

29. Because of the seriousness of the offences with which he was charged, and because he was recalled from licence, he was identified as a Vulnerable Prisoner. R wing, the Vulnerable Prisoners wing was full, and so he was located on C wing in cell C2:14. C wing is used as an overspill for the Vulnerable Prisoners wing. He shared the cell with other prisoners until the evening of 14 June when he was alone for the first time, his cellmate having been moved to another establishment.

30. The cellmate said in interview that he had known the man for three years, first meeting him in Maidstone prison. On 27 May, he returned to Pentonville from court and was asked by prison staff to share a cell with a new reception prisoner. He immediately recognised the prisoner as the man and was pleased to see him. The two men shared Cell C2:14 for a number of days. The cellmate said that the man was initially reluctant to speak about his imprisonment, but eventually spoke about the circumstances of his arrest. The cellmate thought that by talking about it the man had lightened his worries. He went on to say that the man had just finished a 12 year sentence, serving the maximum period in custody without parole. He said the man felt that, all of a sudden a year later, he faced at least a three year recall to prison as well a sentence for the new charges. He said that the man also knew that changes in the law meant that his previous sentences could be mentioned in court. The cellmate said that the man sensed he was up “against it”.

31. The cellmate described the man’s interaction with other prisoners and staff as being kept to a minimum. He described him as a quiet man, “the type of person you wouldn’t notice”. He said that you would not have noticed him because, whenever he was on association, he would sit in the same spot and be quiet.

32. My investigator asked the cellmate if the prison could have seen any indication that the man might have been contemplating harming himself. He said, that he did not think so. The night before he died, the man asked the cell mate and his new cellmate for any old newspapers. They gave him their newspapers and the man went off to his cell. The cellmate said that he was not worried about the man going to harm himself. He did not detect anything from his mannerisms or anything else, and he did not anticipate that the man would cause himself injury.

33. Another prisoner at Pentonville, said that he arrived there on 10 June and was allocated to cell C2:07 which was opposite to the man’s cell. The two men had previously met whilst at Maidstone. The man told him that he had been recalled from his licence and that he had not done anything wrong. He told this prisoner that he was not his usual self. The day before his death, the man asked the prisoner if he was sharing his cell which the prisoner thought might have been because he wanted to share himself. Subsequently on the morning of 15 June, the prisoner said that he saw a lot of activity in the man’s cell, and was told later that he had died.

34. A life sentence prisoner who also arrived at Pentonville on 10 June. He was placed in the cell opposite to the man. The life sentenced

prisoner said that he had been a Listener for the Samaritans for the last four years. Listeners are prisoners who are selected, trained and supported by the Samaritans to provide a listening ear for any prisoner who feels vulnerable and at risk. As well as having face to face contact, prisoners can also use the direct telephone to the Samaritans. As far as the man was concerned, the life sentenced prisoner said that he was quiet and kept himself to himself, but he did not think he was at risk of suicide.

35. A prisoner on C wing located in cell C2:15, who said that he knew the man. They had spoken and he found him to be friendly and polite, but also distant from other people and quiet. The C wing prisoner thought the man was shy. The C wing prisoner was shocked to learn of the man's death and said that he had not thought he would harm himself. When he was interviewed for this investigation, The C wing prisoner said that he felt that the support he received after the man's death was non-existent. He said that he asked to use the Samaritans telephone but was told that it was broken, and he did not see a Listener until four days later.

36. An officer met the man as he was carrying out his duties. He described having a number of conversations with him, and found him to be a pleasant man, who seemed happy and liked to watch television. He said that the man seemed fine with himself. He last saw the man at about 6:00pm on Tuesday 14 June. The man was alone in his cell and the officer asked him how he was doing the man replied "I'm alright, cheers, Gov", and gave a wave.

37. At night, the prison is in patrol state which means that only the Night Orderly Officer (Officer in Charge) has access to all the keys. Other staff carry a cell key in a sealed pouch, to be used in emergencies.

38. A night duty officer started duty on C wing at 8:30pm on 14 June. He was given an electronic pegging wand and a pegging card. The wand allows an officer to record his location at specific points on the wing which are pre-determined by the card. The system is designed to ensure that an officer physically checks the landings every half hour, as well as responding to cell bells or any other events. At the end of the shift, the officer returns the wand to the Night Orderly Officer who downloads and checks the information.

39. The night duty officer physically checked and counted all the prisoners in their cells. Throughout the night he walked the C wing landing, electronically pegging his movements. His pegging routine was carried out correctly. The man did not ring his cell bell during the night. The night duty officer began a further physical check of all

prisoners in their cells on C wing shortly after 5:30am. At 5:45am, he looked inside cell C2:14 and saw the man. He could see clearly that there was a ligature around his neck, made from a bed sheet and tied to, what he believed to be, the outer cage of his window.

40. In accordance with procedures, the night duty officer radioed in his position and radioed call sign “level 1” to indicate that a prisoner had been found hanging. He broke the seal on his key pouch and opened the cell door, ran into the cell and lifted the man up. He shouted to him to see if he could get his attention. The night duty officer removed the anti ligature knife from his belt and cut the ligature off of the man’s neck. He laid him on the ground and tried to get a response. He checked his condition, and then again radioed in his location. He commenced cardio pulmonary resuscitation **(**CPR) with skin to skin contact through the man’s mouth and nose**.** The night duty officer was joined and assisted by a nurse and another officer. The nurse used a defibrillator on the man.

41. An ambulance was summoned to the prison at 5:46am, and arrived at 5:55am. The paramedics took over the administration of CPR at 5:56am, but at 6:05am it was stopped. The cell was sealed for forensic examination, and at 8:30am a doctor pronounced that the man had died.

42. A governor arrived at Pentonville at 6:00am, and immediately took overall command. He ensured all documentation relating to the man was collected and securely stored. All contingency plans were followed and the governor conducted a hot debrief with all the staff involved.

Events after the man's death

43. The Metropolitan Police commenced an investigation, and carried out a forensic examination of cell C2:14. The undertakers removed the man from the prison at 11:50am.

44. The Governing Governor visited the man's next of kin that morning and subsequently delivered the sad news of his death. He appointed a prison family liaison officer who was able to meet the family's initial needs.

45. Members of the man's family visited the prison on 17 June. A Senior Officer met the family on C wing and showed them the cell where the man died. The cell was still sealed, and so the family could only look in through the observation panel. The Senior Officer said that they commented that the cell was untidy, and he explained that items would have been moved as staff attempted to resuscitate the man. He also said that they commented that the cell bars were low, and wondered how he could have hung himself. The Senior Officer said that he explained how the wing operated and informed them that it was not solely for Vulnerable Prisoners.

46. A doctor carried out a post mortem at Camden Mortuary on 17 June. I am still awaiting the results of the post mortem, which will, if necessary result in a supplementary report. The man's medical toxicology report was received at the PPO office on 3 October. It shows that at the time of his death the man had 2.3g/l of Ethanol in his blood. The legal limit for driving is 0.8g/l. Concentrations above 3 g/l are associated with serious toxicity. The deputy governor was informed of this finding on 3 October. My investigator returned to Pentonville on Thursday 14 October and re-interviewed the man's first cellmate. He was aware that the man knew how to make alcohol. However, he said he had no knowledge of the man making it or consuming it at Pentonville. He re-stated that the man was someone who kept himself to himself.

47. My family liaison team, has spoken and written to the man's family but no additional matters have been raised by them.

Clinical Review

48. The clinical review was conducted by a doctor who considered the following information:

    A Inmate Medical Record, including first reception health screen
    B Cell Sharing Risk Assessment
    C log relating to action taken when the man's death was discovered
    D transcript of interview with the healthcare officer who completed the first reception health screen
    E transcripts of interviews with prison staff who were involved with the man in various capacities
    F transcripts of interviews with prisoners.

49. The doctor found that the first reception health screen did not identify any health problems or risk factors for self harm such as alcohol or substance misuse, mental health problems or previous episodes of self harm. This was reflected in the healthcare officer's contribution to section three of the cell sharing risk assessment where she assessed the man as low risk of harm to others, with no concerns about self harm.

50. The man had no further contact with healthcare services in the prison.

51. From accounts of prisoners and prison staff, the doctor established that the man appeared to be quiet, kept himself to himself, and was reluctant to talk about his feelings during his stay. The man's cell mate who had known him previously, felt he was initially shocked to be back in prison but seemed to open up to him and become more relaxed and calm as time went on. A fellow prisoner who had known him previously noticed that he seemed a bit upset and quiet, compared to how he had been when they were together in Maidstone in 2004. This was particularly so on the day before the man was found hanging. However, he did not appear to have spoken or behaved in a way that aroused any suspicion of the possibility of self harm during the three weeks he was in custody.

52. The man's first reception health screen was conducted in accordance with usual procedures and the health record was completed clearly and fully. There were anomalies in that the prison officer who completed section two of the form assessed his risk as

medium, but the healthcare officer completing section three assessed his risk as 'low'. [1]

53. The man's subsequent demeanour and behaviour did not suggest any mental health problems requiring intervention from the healthcare team or prison staff.

54. The clinical reviewer considered that it might be significant that the man took his own life on the first night that he was alone in his cell. However, there had been nothing to indicate that he might be in more need of the companionship of a cell mate then any other prisoner.

55. The reviewer went on to conclude that the actions taken after the discovery of the man appeared to be timely and appropriate. Unfortunately he was discovered too late for resuscitation to be successful. The review states that prison procedures were correctly followed throughout the man's time at Pentonville, and his death could not have been foreseen or prevented under the present conditions.

56. The clinical review contains the following recommendations:

i Consideration should be given to the way in which cell sharing risk assessment is documented. The form does not clearly distinguish between the risk of a prisoner harming others in the cell, the risk to the prisoner from a cell mate and the risk of a prisoner harming himself.[2]

ii Strategies to reduce risk of fatal self harm in prison should include assessment of the effect of single cell occupancy and lack of television in cells on the mental well being of prisoners.[3]

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[1] I am aware of much recent work within the Prison Service on the subject of cell sharing risk assessment. I simply draw to the Service's attention these views from an independent clinician.
[2] I share the clinical reviewer's concern about the absence of in-cell television. I make my own recommendation in relation to this matter.

Conclusion

57. The man was arrested whilst on licence and was charged with serious offences. The Probation Service revoked his licence. He expected to be imprisoned until 2008 following the revocation of his licence. A further substantial term of imprisonment would have followed conviction for the new offences.

58. The man was remanded in custody in May and taken to Pentonville. During the reception process and his time in the prison, he did not present as a person likely to harm himself. He shared a cell with other men until 14 June, and was then alone for the first time since his arrival.

59. Facilities in the man's cell were limited. There was no electricity, which meant that there was no television. He would spend at least 12 hours alone overnight. This is self-evidently a long time to be without human contact or other distraction.

60. During the evening of 14 June, the man gave no outward indication that he might harm himself, and he was last seen alive at approximately 8:30pm during the C wing roll check. He was found hanging in his cell at 5:45am the following day.

61. All procedures were followed correctly. However, some of the prisoners interviewed in the course of this investigation felt they received little or no support from prison staff.

62. The post mortem toxicology results showed that the man had consumed a substantial amount of alcohol. The toxicology report on another prisoner who died at Pentonville two days earlier showed a similar result. The investigation team re-interviewed prisoners and examined security incident reports.

63. There was no indication from the security reports that a special problem concerning the production of alcohol has been identified at Pentonville.

Recommendations

Operational

1. The Governor should review the prison's arrangements for providing support for prisoners after a death in custody.

2. The Governor and Area Manager should review the programme for installing in-cell electricity and in-cell television at Pentonville with a view to accelerating the programme as resources allow.

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

Good Practice

1 The two officers and the nurse should be commended for their attempts to resuscitate the man.