INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP PENTONVILLE IN OCTOBER 2005

Report by the Prisons and Probation Ombudsman for England and Wales

February 2007

This is the report of an investigation into the death of a man at HMP Pentonville on 25 October 2005. He was found hanging in his cell and died less than 24 hours after arriving in prison custody. The man was Algerian by birth. He was 32 years of age.

The man was detoxifying from both alcohol and drugs when he came into prison. When he died, he was receiving only symptomatic relief as he was not due to receive his prescribed methadone until later in the afternoon.

My colleagues and I offer our sincere condolences to his family and friends on their sad loss. I much regret the delay in the issuing of this report. This was caused by a wait of almost 12 months before I received the clinical review commissioned by the relevant Primary Care Trust.

The investigation was led by one of my colleagues. Its purpose was to establish the circumstances and events surrounding the man's death, including the quality of care provided by the Prison Service. I am grateful for all the assistance that the investigation team received from the Governor of Pentonville and his staff. I am particularly indebted to the Deputy Governor, who acted as the establishment's liaison officer.

Several aspects of this investigation have caused me concern. First, there was clear evidence of the man's risk of self harm in documents completed while he was in police custody. However, these appear not to have been known to reception staff at Pentonville. Second, the prison's own incident log has gone missing and there are significant differences in the accounts that staff have given. Third, I am critical of aspects of the actual response of healthcare and discipline staff when the man was discovered.

I make seven recommendations, largely based on the clinical review.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **FEBRUARY 2007**

CONTENTS

SUMMARY

The man was born in Algeria in 1973. He was 32 years old when he died at HMP Pentonville, apparently by his own hand, on 25 October 2005. The man had been remanded in custody from Highbury Corner Magistrates' Court the previous day.

The man had been in police custody between 22 and 24 October 2005 at Islington Police Station where he had been on constant watch for a time. He said he had attempted suicide the year before and was suffering withdrawal symptoms from alcohol abuse and illegal drug use. A doctor noted that he had a number of healed superficial scars over his body but did not indicate that he had any current thoughts of self-harm or suicide. He was given medication for the withdrawal symptoms.

During his reception at Pentonville, he denied any thoughts of suicide or self-harm. During the first reception health screen, the nurse noted, as others had, that he was withdrawing from alcohol and drugs. She also noted that he had been in psychiatric hospital in France 10 years previously, suffering from depression and hearing voices. She referred him to see a psychiatrist and the substance misuse team the next day. The nurse did not see the medical notes from the police doctor, nor the prisoner escort record, and did consider that it was necessary to open an ACCT form (a form resulting in monitoring and support for those at risk of self harm). The man then saw a doctor who prescribed medication to ease the withdrawal symptoms.

On the morning of 25 October, the man saw a member of the substance misuse team who made an assessment and organised for him to start a 10 day methadone detoxification programme later that day. He was also administered medication to ease his withdrawal symptoms. His first dose of methadone on the detoxification programme (prescribed by a doctor) was due to be administered at 3.30pm. Later in the morning, he asked an officer if he could move into a shared cell with another prisoner who also spoke French and whom he said was a friend. The officer organised the move and checked on him shortly after when he appeared settled. She had no concerns that he was a risk to himself or others.

Shortly after lunch, a prisoner looked into the man's cell through the spy hole and saw him hanging at the back of the cell. His cellmate was asleep. Staff responded and CPR was commenced. Sadly, the man was later pronounced dead at Whittington Hospital.

During his short time at Pentonville, there is no evidence that he gave any indication to anyone else that that he had any current suicidal thoughts.

The clinical review carried out by the Islington Primary Care Trust concludes that 'the care and management received by the man during his short period at HMP Pentonville was of an acceptable standard and that staff had conducted the appropriate risk assessments to assess whether he was a risk to himself or others.' The doctor says that the man was appropriately referred to see a Detox

worker, a member of Counselling, Assessment, Referral, Advice and Throughcare services (CARATS) which provides support and advice for drug misusers, and for a mental health assessment. However, the doctor draws attention to a number of issues, specifically regarding the healthcare response on 25 October.

The clinical review contains a number of recommendations which I have endorsed. I have also made one recommendation of my own.

This report is critical of several aspects of the care offered to this man and to the response when he was found hanging.

THE INVESTIGATION PROCESS

1. Two colleagues of mine carried out the investigation for the Prisons and Probation Ombudsman.

2. During the course of initial inquiries, the investigation team was shown around Pentonville and visited the cell where the man died. They reviewed all the relevant documentation and established a chronology of events. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. There were no responses to these notices.

3. One of my family liaison officers contacted the solicitors acting for the man's brother. My family liaison officer offered them the opportunity to meet with him and with the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed on behalf of the man's family. The man's brother has returned to Algeria. No issues were raised on his behalf by the solicitors.

4. The investigation team met a representative of the local branch of the Prison Officers' Association (POA), and a representative of the Independent Monitoring Board (IMB), to tell them about the investigation process. Fourteen members of staff were interviewed during the course of the investigation. They were all offered the opportunity of being accompanied by a work colleague or Trade Union official.

5. The investigation team contacted Her Majesty's Coroner to tell him of the nature and scope of the investigation and he provided a copy of the post mortem report of 28 October 2005. The post mortem report recorded the cause of death as hanging. The toxicology report showed traces of diazepam and nordiazepam which were within a therapeutic range.

6. The Assistant Director of Nursing, Islington PCT, undertook a clinical review of the healthcare provided to the man who died while at Pentonville.

HMP PENTONVILLE

7. Pentonville is a 160 year old local prison which accepts all suitable prisoners from courts within its catchment area in North London. It has a certified normal accommodation of 897 without overcrowding, and an operational capacity of 1,189.

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

9. The prison has links with outside agencies such as the Probation Service who sit on the drug strategy group and they also have a group to represent prisoners' families. The Rehabilitation of Addicted Prisoners Trust (RAPT) provides drug rehabilitation programmes. Pentonville is also represented on the Camden and Islington Drug Action Team.

10. The man was the sixth prisoner at Pentonville to die apparently by their own hand since June 2004. Five out of these six deaths have taken place within days of the prisoner's arrival at Pentonville.

11. Following these previous tragedies, the prison has worked hard to improve its practices. I understand that the recommendations from earlier investigations have been implemented and there has been a major emphasis on safer custody led by the Head of Residence. I recognise these much needed improvements. However, there is still a very long way to go.

12. The most recent report by HM Chief Inspector of Prisons, Ms Anne Owers, was published in September 2006 (it was an unannounced inspection, conducted in June 2006, to follow up a full inspection that had taken place in January 2005). Ms Owers's report said: 'the last inspection had a particular concern about the support of prisoners in early days of custody, particularly as five out of six recent self-inflicted deaths had taken place within days of prisoners' arrival. Though the physical environment for first night prisoners had improved, the arrangements to support them did not work effectively, indeed, more prisoners than in 2005 said they felt unsafe on their first night.'

EVENTS PRIOR TO 24 OCTOBER

13. On 22 October, the man was taken into custody at Islington Police Station and charged with offences of burglary. At 8.20pm, he was seen by a police doctor who noted that he suffered from depression and had previously self harmed. He was put on close observation but it is not clear how frequent the observations were.

14. At 1.15pm on 23 October, while still in police custody, the man was again seen by a doctor who noted that he had attempted suicide a year ago. He was placed on a constant watch. The doctor also noted that the man was withdrawing from drugs, admitted to using heroin, crack and alcohol, and had healed superficial scars all over his body. He was given medication for the withdrawal symptoms.

15. At 5.15pm the man again saw the doctor who noted he was still suffering from the symptoms of withdrawal and felt sweaty. He was subject to ongoing medical review. It appears that he was prescribed and administered symptomatic relief but the details are not clearly documented.

EVENTS ON 24 OCTOBER

16. The man was seen again by the police doctor at 2.30am on 24 October. There was no change in his condition and he and was still suffering withdrawal symptoms. However, he was assessed as fit for detention on this as on the previous examinations. Later that day, he was taken to court. There is no evidence of him receiving any further medication for withdrawal symptoms before he attended court.

17. A Prisoner Escort Record (PER, PART A) was completed for his transfer from Islington Police Station to Highbury Corner Magistrates' Court by the Custody Sergeant. He noted that the man suffered from depression, mental health issues and was a heroin addict. The suicide/self harm warning box has also been ticked.

18. His cellmate at Pentonville told police that he had also shared a cell with him at Highbury Corner Magistrates' Court and that the man had tried to hang himself with his jumper while in custody there. The PER (PART B) for him does not record any incidents while he was in custody at Highbury Corner.

19. The court remanded him into custody at HMP Pentonville. No PER was available for his transfer from court to Pentonville.

20. The first reception health screen was completed by the reception nurse. She noted, as others had, that he had alcohol and drug withdrawal problems. The nurse told the investigation team that the man was anxious during the health screen, and she had told him he would be prescribed valium to ease the withdrawal symptoms. The man seemed happy with this. She said that he told her he wanted methadone, which she said he would get when he started the detoxification programme the next day. She noted that he had been in psychiatric hospital in France 10 years previously, suffering from depression and hearing voices. The reception nurse referred him to see a psychiatrist and the substance misuse team the next day. She confirmed in interview that she had considered him to be 'stable' during this assessment and did not consider that it was necessary to open an ACCT form for him.

21. The man mentioned to the nurse that he had bumped his head on 19 October, a couple of days before he was taken into police custody. However, when she examined him she did not find any visible injury.

22. The reception nurse did not see the PER for his transfer from the police station to court to complete her assessment, nor the records of the medical examinations undertaken while he was in police custody. He told her he had last taken drugs on 23 October. However, as this was the day before, he had actually been in police custody then.

23. All prisoners see a doctor within 24 hours of arrival at Pentonville. That evening, the man saw a doctor who prescribed diazepam (valium) for his drug withdrawal symptoms.

24. The man told the reception nurse he had previously self harmed in September 2005 and the police doctor had noted that he had healed superficial scars all over his body. However, these scars were not noted during any of the medical assessments at the prison.

25. After he was seen by the doctor, the man saw the induction officer who completed an induction/reception checklist. The induction officer noted that the man said he had previously self harmed because of drug misuse when he was withdrawing, but was alright if he had medication. The man was aware of the Listeners scheme. (Listeners are prisoners who are trained by the Samaritans to help other prisoners who are having difficulties.)

26. The induction/reception checklist was ticked to confirm that immediate issues were addressed, that the man did not need an interpreter (it was noted that he was an EU citizen, which was incorrect), and that the anti bullying policy, first 24 hours in custody and complaints process were all explained. I note that the booklet handed out to prisoners, 'Information for Residential Prisoners', is only available in English.

27. The induction officer did not recall having access to the man's PER completed for his transfer from the police station to court. He said that the man had engaged well and made good eye contact during the assessment and, although he had again been open about his drug dependency and history of self-harm, he did not give any indication that he was at risk of self-harm or suicide. The officer did not, therefore, open an ACCT form.

28. The man's cellmate contradicts the induction officer's account. He said that he heard the man tell the officer that he was suicidal and had showed him the self harm marks on his chest.

29. A cell sharing risk assessment was undertaken by another officer. The man was assessed as a low risk for sharing a cell which meant he was suitable for multi cell location. The 'Yes' boxes were ticked to say that the man abused alcohol, was currently dependent on drugs or alcohol, and that there was evidence of him previously being on a suicide and self harm awareness form. He was located in a single cell in the first night centre on A wing (he was to move into a shared cell the next morning – see below).

EVENTS ON 25 OCTOBER

30. Induction staff interview all new prisoners on their first morning in prison custody. HM Chief Inspector of Prisons has recommended that there should be separate induction for those on a detoxification programme. However, it does not appear that a separate induction was scheduled for the man who died.

31. The man had a detoxification assessment which was undertaken by a second nurse following the referral from the reception nurse. The man presented to her as a poly-drug user. He said he had been injecting heroin and crack cocaine daily for four months. His urine tested positively for opiates, benzodiazepine and cocaine. She noted that he was 'withdrawing objectively.' She referred him to the mental health team and the CARATS team which provides support and advice for drug misusers. He told her he was not suicidal or at risk of self harm. She recommended methadone on a standard ten day detoxification regime and zoplicone (a sleeping drug). He then saw the doctor who prescribed the methadone (level 2, the standard ten day detox regime) and zoplicone for five days. The first dose of methadone was due to be administered to him at around 3.30pm on 25 October.

32. Also that morning, the man asked the movements' officer if he could move cells to share with another prisoner whom he said he had known for a few years and who spoke the same language. (In her subsequent incident report, the officer stated that the man told her he would harm himself if he was not allowed to move cells.) After authorisation from a senior officer, the man moved into the cell with the prisoner he knew. The movements' officer said that the man seemed happy with the move and, as a consequence, she did not think it was necessary to open an ACCT form for him. She said she checked on him shortly after he moved cells and he was laughing and joking. My investigator noted that the Chief Inspector's report mentions that prisoners who are withdrawing should be located in a single cell, and not located in a shared cell without a further risk assessment. This did not appear to happen in this case.

33. At around 2.10pm, another prisoner looked through the spy hole of the man's cell to ask for a cigarette. He saw him hanging from a ligature made from a bedsheet and attached to the window. He banged on the cell door, and shouted out for an officer to help. The man's cellmate was apparently asleep in the cell having taken a sleeping tablet (diazepam) earlier in the day. He said he woke up when he heard the shouting and banging on the door.

34. The sequence and timings of events from the time when the man was found hanging to the time he was removed from his cell have been very difficult to clarify. This is because the investigating team have not had access to the formal incident log of events, despite efforts to obtain it. There are also inconsistencies in staff statements and interviews.

35. It appears that three officers immediately entered the cell. Two of them supported the man by taking his weight. The third officer arrived and cut the

ligature with an anti-ligature knife and the man was placed in a seated position on a chair. (The third officer was the only officer who was carrying an anti-ligature knife.) The second officer left the cell as soon as the ligature was released. It appears that the man's cellmate was taken out of the cell by the first officer. In his interview with the police, the cellmate said that he was quickly taken out of the cell and had spoken to a Listener.

36. A Physical Education Instructor (PEI) was on the wing collecting prisoners for the gym when he heard the commotion and made his way to the man's cell. In interview, he said he entered the cell and saw the man sitting on a chair supported by two officers. He said that the man showed 'no signs of life' and it appeared that staff had not initiated any first aid or resuscitation before he arrived in the cell. He explained that he told the officers to lay the man on the floor so he could administer Cardiopulmonary Resuscitation (CPR). All staff present at this time report that the PEI was about to commence CPR when the first nurse on the scene arrived and, from the cell door, instructed staff to place the man in the recovery position. This instruction appears to have been given by the nurse without first checking his vital signs.

37. The first nurse said she arrived at 2pm with another nurse. She confirmed that she instructed staff to place the man in the recovery position while she was standing in the cell doorway, and said she had not realised that he was not breathing. She assumed that he had suffered an epileptic fit. The PEI is trained in administering first aid and he said that he told the first nurse on more than one occasion that the man was not breathing and should not be put in the recovery position. This was verified by the first officer. The PEI maintained that there had been a delay between the man being placed on the floor and resuscitation being commenced due to the first nurse's insistence that the man be placed in the recovery position.

38. At interview, the first nurse said that the man looked 'pinkish' in colour. Once she entered the cell, and found that he did not have a jugular pulse, she immediately started 'basic life support.' She also said that two other officers were present in the cell although they were not mentioned by other staff as being actively involved.

39. According to the PEI, the first nurse then left the cell for approximately five minutes, followed by the second nurse whom he thought had left to get another piece of equipment. A wing officer arrived at the cell just as the first nurse left. He was responding to a call on his radio at approximately 2.10pm requesting immediate healthcare assistance. According to the first officer and the wing officer, the PEI then commenced chest compressions on the man, although the PEI maintains that he did not commence CPR at any time.

40. According to the wing officer's account, after arriving at the cell he spoke to the PEI and established that the man required immediate paramedic assistance. He contacted the Communications Room straightaway to request an ambulance, which he thought arrived less than five minutes later. He also said that a third nurse arrived at the cell at this time, and asked him to call a prison doctor via his radio which he did immediately.

41. The first nurse maintains that, before she left the cell and in the presence of the second nurse, she had given the man 15 chest compressions. This has not been confirmed by the wing officer and the first officer who were in the cell at that time.

42. Statements and interviews with other staff conflict with the evidence given by the PEI and suggest that the first nurse returned to the cell with a second nurse and an ambu bag approximately 30 seconds after leaving.

43. The first nurse said that she left the second nurse in the cell while she went to collect the hotel 9 (resuscitation bag), although this is contradicted by the fourth nurse in his interview. He said that the second nurse had not been in the cell when he arrived and that the man was not at the time being resuscitated. He maintained that he collected the hotel 9 bag on the way to the cell shortly after hearing the emergency call at 2.30pm. He also said that, on his way to the cell, he saw a member of healthcare staff, a nurse who had responsibility for the Hotel 9 radio that day. The fourth nurse recalled that he was surprised that, having told nurse Hotel 9 that he was taking the hotel 9 bag to the cell, she had not followed him there.

44. Nurse Hotel 9 recollection of events between when she heard the emergency call and when she arrived at the cell are not clear. For example, she said that she had not heard the initial emergency call (which records confirm was called three times) and learned of the incident from the fourth nurse. She thought that the fourth nurse had already attended the incident when she saw him and that he had returned to the emergency room for a piece of equipment (although she could not recall what that was). Nurse Hotel 9 said that she had not seen the fourth nurse with the Hotel 9 bag, although she did acknowledge she noticed that the equipment had been taken from the emergency room around the time the fourth nurse passed her in the corridor.

45. When asked what equipment was in the cell when he arrived there, the fourth nurse replied ‘none’.

46. Nurse Hotel 9 confirmed that, when she arrived at the cell, the fourth nurse was using the ambu bag on the man, and another nurse was in overall charge instructing staff. Nurse Hotel 9 estimated that, from the time she arrived at the cell, it took 15 minutes for the paramedics to arrive. In contrast, the wing officer suggested the interval was nearer three minutes.

47. In interview, the fourth nurse described in detail how he instructed the first nurse to take over chest compressions while he began to administer oxygen via the ambu bag. He recalled that, shortly after this, he instructed the second nurse (whom he recalled had just entered the cell) to take over from the first nurse so he in turn could be relieved from administering oxygen to apply the automatic defibrillator. The fourth nurse recalled that he had difficulty in knowing whether the defibrillator was working and focused on trying to establish intravenous access for the paramedics to administer drugs.

48. According to prison records, paramedics were called at 2.17pm and two teams arrived. An Immediate Response Team arrived at 2.18pm by car and another team arrived by ambulance at 2.27pm. They took over resuscitation and the man was moved to A2 landing, where there was more space to continue CPR. He was taken by the paramedics to Whittington Hospital at 2.52pm, escorted by two prison officers. The paramedics continued to perform CPR on the way to the hospital but the man was declared dead shortly after at 3.06pm.

ISSUES

Failure to share of information

49. It is clear from the man's notes that, in the two days that he was in police custody, he had been subject to close observation on 22 October and constant watch on 23 October. It has not been noted whether this was continued on 24 October. During his time in police custody, the man was assessed by a police doctor on four separate occasions and said that he had an alcohol problem and used crack and heroin, and that he had attempted to commit suicide a year previously. He also volunteered this information when he was interviewed for the cell sharing risk assessment and subsequent medical assessments at Pentonville. Moreover, the PER form for his transfer from police station to court has been ticked for suicide/self-harm, and the medical records from the police detailed that he had (healed) superficial scars all over his body. However, these scars were not noted during subsequent medical examinations at the prison. And it appears that neither the PER form, nor the clinical information, was available to the nurse who conducted the first reception health screen.

50. Decisions about a prisoner's safety must be made in the light of all relevant information. I am therefore particularly concerned that the records of this man's time in police custody and the PER form were apparently not available during the reception process at Pentonville.

    The governor should review the information available to staff during the reception process.

Clinical care

51. On 31 October 2005, my investigator asked the PCT to conduct a clinical review and this was undertaken by the Assistant Director of Nursing, Islington PCT. The review was not received until 9 October 2006. The Assistant Director noted that 'the care and management received by the man during his short period at HMP Pentonville was of an acceptable standard, and that staff had conducted the appropriate risk assessments to assess whether he was a risk to himself or others.' She said the man was not placed in a situation (such as segregated unit or a cell with an at risk prisoner) which might have increased the risks of self-harm. She concluded that he was appropriately referred to see a detoxification worker, a member of CARATS, and for a mental health assessment.

Response on 25 October

Healthcare staff

52. Nevertheless, the clinical review also drew attention to a number of issues regarding the response of healthcare and discipline staff on 25 October. She reported that, 'whether prompter action by staff attending the incident could

have led to a successful resuscitation cannot be ascertained from the written and verbal evidence available. However, the lack of training of prison officers and the availability of basic equipment required to manage a life threatening incident as well as issues relating to the competency of some members of the healthcare staff to instigate basic life support have been key features of this incident.' The clinical reviewer has made a number of detailed recommendations and I am grateful to her for doing so. I endorse her recommendations and repeat those which appear to have the greatest significance.

53. I am concerned that the member of healthcare staff with responsibility for attending to emergency situations (Hotel 9) did not respond to the emergency call immediately. The emergency call was in fact called three times before the member of staff responded.

    All healthcare staff undertaking the hotel 9 role must be made aware of their responsibilities when responding to an emergency call.

54. I am also concerned that the first nurse to arrive did not assess the man before instructing the officers to reposition him in the recovery position. She also failed to acknowledge the PO's assessment which had confirmed that the man was not breathing normally and required immediate resuscitation. There is also evidence that the nurse left the cell to collect equipment without establishing basic life support measures and ensuring that staff within the cell could maintain continuous chest compressions. It is unclear from the evidence whether there was another nurse in the cell at this time.

55. The clinical reviewer has suggested that the healthcare manager should review healthcare staff's understanding of their accountability as the first on the scene in a life threatening situation. She also said there was a need for all healthcare staff to understand their role and responsibilities with particular reference to resuscitation equipment.

    The healthcare manager should provide training to enable all healthcare staff to understand their roles in life threatening situations and to be confident to perform them.

56. It is clear that a significant number of healthcare staff attending did not have sufficient knowledge of the contents of the resuscitation bag.

    The healthcare manager should ensure that all healthcare staff are familiar with the contents of the emergency resuscitation (Hotel 9) bag and are trained in how to use the equipment.

Discipline staff

57. Annex C of Prison Service Order (PSO) 2700, Action following self-harm: emergency procedures, states that in all cases staff should:

> 'summon help and request emergency medical assistance and first aid equipment, enter the cell as soon as possible, following the local strategy for safely doing so and give a concise report on handover to health care staff. In cases where the prisoner is found hanging staff must: support the body to reduce constriction. Staff should be aware of the potential for injury to themselves from such a process, and should consider utilising any alternative methods of support, such as items of cell furniture. Cut the prisoner down. Cut and then release the ligature immediately the prisoner has been cut down, preserving the knot if possible. Place the prisoner on his / her back on a flat, solid surface. Check for signs of life, i.e. breathing, pulse, any movement of the body. If not breathing and / or no pulse is present, clear airway and attempt resuscitation, using a face mask with non-return valve, unless rigor mortis of the limbs has clearly set in. (Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death, making it virtually impossible to bend the wrists, elbows or knees.) If conscious / revived, place in recovery position.'

58. The first officers in the man's cell did not commence CPR and did not have mouth guards. All staff who may be called on to respond to an apparent death in custody must be made aware of their responsibilities in this respect as detailed in PSO 2700. As they may be called on to perform mouth to mouth resuscitation, they must also have immediate access to barrier masks. (This is to reduce the chance of transmission of infectious disease from victim to responder.) There are a number of small systems that are available that could be carried unobtrusively on officers' belts.

    The governor should ensure that all staff are aware of their responsibility in responding to life threatening situations as detailed in PSO 2700.

    The governor should ensure that staff who may be called on to perform mouth to mouth resuscitation have immediate access to barrier masks.

59. Only one officer appears to have been carrying an anti-ligature knife, although a significant number of staff have been issued with them. I understand that a national instruction relating to the issuing and carrying of cut down tools is shortly to be published. In light of this welcome development, I make no recommendation here.

60. The sequence and timings of events and actions of staff involved in trying to assist the man are unclear. No formal log was available to the investigation team, despite efforts made to obtain it. There are also inconsistencies in statements and interviews.

Other matters

61. The man does not appear to have had difficulty communicating in English; by all accounts his grasp of English seems to have been pretty good. However, English was not his first language and he was moved to a cell (at his own request) with another inmate who also spoke French. Nevertheless, although apparently not a feature in this case, I am concerned that important documentation such as the induction booklet 'Information for residential prisoners' is only available in English.

    Important documentation should be available in a range of languages representative of the prisoners held in Pentonville.

62. Pentonville's local instruction to staff is to locate prisoners who are withdrawing from drugs in single cells (unless located with another prisoner who is withdrawing). The man was withdrawing from drugs and alcohol but was in fact moved to a shared cell at his own request. I note in this case, however, that it was in his own interest that he was moved as he ended up sharing with a prisoner he knew and who spoke the same language.

63. The recent report from HM Chief Inspector of Prisons is very critical of the reception facilities at Pentonville, and I am conscious that the man who is the subject of this report died within 24 hours of arriving at the prison. The prison should act speedily upon the Chief Inspector's recommendations to improve these facilities.

RECOMMENDATIONS

The governor should review the information available to staff during the reception process.

All healthcare staff undertaking the Hotel 9 role must be made aware of their responsibilities when responding to an emergency call.

The healthcare manager should provide training to enable all healthcare staff to understand their roles in life threatening situations and to be confident to perform them.

The healthcare manager should ensure that all healthcare staff are familiar with the contents of the emergency resuscitation (hotel 9) bag and are trained in how to use the equipment.

The governor should ensure that all staff are aware of their responsibility in responding to life threatening situations as detailed in PSO 2700.

The governor should ensure that staff who may be called on to perform mouth to mouth resuscitation have immediate access to barrier masks.

Important documentation should be available in a range of languages representative of the prisoners held in Pentonville.

The Prison Service has accepted all the recommendations.
There were no comments from the man's family.