Investigation into the circumstances surrounding the death of a man at HMP Pentonville in January 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is a report of an investigation into the death of a man. He was found hanging in a cell in the segregation unit at HMP Pentonville in January 2010. He was 34 years old.

I would like to offer my sincere condolences to the man's family for their loss. I hope that my report addresses the concerns that they have raised.

The investigation was carried out by one of my investigators. We would both like to thank the Governor, the prison's liaison officer and staff at Pentonville for their help and co-operation. A clinical review was carried out by the clinical reviewer, who was commissioned by the local Primary Care Trust. I would like to thank him for a thorough and helpful review.

The man was a young man with a history of mental health problems before entering prison. These were well documented, and although the information was requested by his mental health key worker, sadly it was not passed on to other members of the Mental Health Team until after he died.

It is clear to me that communication within the team was poor and that staff inexperience meant that important information was not disseminated. However, it is impossible to say whether this ultimately had an impact on the man.

I judge that staff in the segregation unit handled the man with intelligence and respect, and tried to encourage him to open up about his feelings. Despite their shock at finding him hanging, they worked hard to try to resuscitate him.

The clinical reviewer makes seven recommendations which I endorse. I understand from my investigator that the Head of Healthcare has already taken steps to ensure that improvements are made in the delivery of their services. I make an additional recommendation about contacting the prison out of hours or during public holidays.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **October 2010**

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SUMMARY

The man was 34 years old and was remanded to HMP Pentonville on 9 October 2009. He was assessed in reception and it was noted that he had been on a constant suicide watch at the police station as he had said he felt suicidal and at risk of harming himself. He said that he had attempted to take his life on a number of occasions in the past.

He was referred to the mental health team at Pentonville who assigned a key worker. The key worker went about collating information about him from outside agencies. Unfortunately this information was not shared with the rest of the team. He met his key worker, but no formal assessment was ever carried out. At the time of his death he had an outstanding request to attend bereavement counselling outstanding.

The man had various altercations with other prisoners, mainly due to the debt he incurred through borrowing tobacco. He was moved around the prison because of the threats made against him.

On 9 December, he was moved to the segregation unit as he had been involved in a fight with another prisoner. This time passed without incident, and staff had little recollection of his time there. He remained there until 13 December.

A month later, on 5 January, the man was back on a wing and sharing a cell with another prisoner. He made a ligature which he had tied loosely but had not put around his neck. His cell mate alerted staff and he was made subject to suicide prevention measures.

The man had two fights with different prisoners the next day. Although he insisted he was not the instigator of the attacks he was taken back to the segregation unit. The Governor who agreed the transfer knew that the man was being monitored by the suicide prevention procedures, but felt this was the safest place if more frequent observations were made.

On the morning of 8 January, the man attended an adjudication hearing for the alleged assault on one of the prisoners. (This is an internal process to investigate an incident and decide, if the charge is proven, an appropriate punishment). He asked to be represented by a solicitor, so the hearing was adjourned. He was taken back to his cell where he was served lunch and seen by a doctor doing his rounds.

At 1.00pm, a member of staff carrying out routine observations saw that the man appeared to have put a ligature around his neck and tied it to a tap on the sink unit. Staff immediately went into the cell, cut the ligature and attempted resuscitation, along with paramedics and doctors who arrived shortly afterwards. Sadly they were unsuccessful and he was pronounced dead.

The post-mortem revealed that the man had alcohol in his blood when he died. This did not come to light until after the draft report was issued and the inquest had taken place. Despite enquiries at the prison, the investigator was unable to establish how he could have obtained alcohol whilst in the Segregation Unit.

The clinical reviewer makes seven recommendations which I endorse. These surround the communication and procedures within the mental health team and sharing of information. I make one additional recommendations.

THE INVESTIGATION PROCESS

1. The investigation was conducted on my behalf by an investigator. On her initial visit to HMP Pentonville she met staff and visited the cell where the man died. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had information relating to his death to contact her. No further witnesses came forward.

2. The investigator reviewed the man's prison and health records, in addition to other documentation. Interviews were conducted with 14 members of staff on 23 and 24 February and 31 March. I commissioned a clinical review from the local Primary Care Trust which was completed by the clinical reviewer. The investigator carried out joint interviews of healthcare staff with the clinical reviewer on 31 March.

3. One of my Family Liaison Officers (FLO) wrote to the man's family to explain the purpose of the investigation and invite them to raise any concerns they wished to be considered and addressed as part of the investigation.

4. The FLO subsequently spoke to the man's aunt. The aunt said her main concern was her nephew's location in the segregation unit shortly before his death and the detrimental effect this environment may have had on his state of mind. She explained that her nephew had mental health problems. He had been compulsorily admitted to psychiatric hospital twice before and was receiving psychiatric intervention in prison and medication to help manage this. The aunt further questioned whether prison was an appropriate place for her nephew given his mental health needs.

5. The man's aunt said that she received a distressing letter from him on New Year's Eve in which he spoke about his despair and wanting to end his life. She was very worried and attempted to contact staff at the prison on a number of occasions to raise her concerns. She described her frustration at being put through to the chaplaincy, the family liaison officer and the Governor, with no reply. This, she thought, was attributed to low staffing levels on New Year's Eve. She said that she felt at a loss to know what to do. Her nephew rang her back a couple of days later to say that he was okay and was "just been silly". She questioned whether there should be a helpline available at all times, particularly during holiday periods when prisoners may feel more vulnerable, for anyone who has concerns about the safety and well being of a prisoner.

6. The man's aunt also said that she was aware that he had not received any of the Christmas cards and presents the family had sent him. She asked why this was and the rationale behind it, given that he was a vulnerable prisoner. The investigator can confirm that copies of letters and Christmas cards taken from his cell after he died were made available to the Ombudsman, indicating that he had received them. The aunt later clarified that she had been referring to a parcel which she sent to him at Christmas. She confirmed that this was returned with his belongings after his death.

7. The man's aunt spoke very positively about the help and support she received from the prison following his death and said she "couldn't fault them". She acknowledged how distressing it must have been for the staff who found him and thanked them for all they had done for him. I hope this report clarifies any issues that may remain unclear for the man's family and helps them better understand what happened in the time leading to his death.

8. Following disclosure of the draft report, the man's family questioned how he would have access to alcohol, particularly as he was located in the Segregation Unit prior to his death. I can appreciate why this is a matter of significant concern for the family. Despite enquiries at the prison, it has not been possible, however, to establish how he could have obtained alcohol whilst in the Segregation Unit. His family also felt that his bi-polar condition, which meant his personality and mood could quickly change, along with a history of suicide attempts should have prompted staff to look beyond his immediate presentation. The man's family also wanted it known that he did not regularly take cannabis. Most significantly, they raised concerns about the lack of training for staff, especially in relation to his key worker. It was felt that the prison needed to address this matter as a priority and they welcomed the recommendations to improve practice in this area. They also felt that first aid training should be a mandatory requirement for all prison officers. The family feel strongly that staff do not appear to be given adequate support or training to fulfil their roles. This, they believe, has ultimately resulted in someone's death. They want to make sure lessons are learned and practice is changed so the same thing can not happen again.

HMP PENTONVILLE

9. Pentonville is a prison serving the London courts. Built over 150 years ago, it has an operational capacity of 1,150 prisoners.

Healthcare

10. Pentonville has a new purpose-built healthcare centre offering both inpatient beds and a day care facility for prisoners with mental health problems. There are primary care facilities on the wings, including a consulting and dispensary area. Healthcare staff are available 24 hours a day. Doctors, mental health and nurse-led clinics are available, as well as a range of more specialised services.

Previous deaths at Pentonville

11. This is the 16th death at Pentonville that my office has investigated since becoming responsible for investigating all deaths in prison custody in April 2004 (there has been another death since, in July 2010.) The main issues raised as a result of the man's death are mental health referrals and assessments, communication and maintenance of medical records.

Assessment, Care in Custody and Teamwork (ACCT)

12. Assessment, Care in Custody and Teamwork (ACCT) is a care planning system whereby staff can work with the prisoner to provide individual care to those at risk of harming themselves or of suicide. Levels of observation can be tailored to meet the prisoners level of risk, ranging from constant 24 hour monitoring, to hourly observations and anything in between.

Samaritans and Listeners

13. The Samaritans provide a confidential telephone support service for prisoners in distress or at risk of harming themselves. Listeners are prisoners selected, trained and supported by the Samaritans to provide a similar service in custody.

Segregation unit

14. The purpose of segregation is to maintain safety, order and discipline and respect for human dignity. Segregation can be necessary to help prisoners address negative aspects of their behaviour and return to normal location as soon as possible.

15. A prisoner may be segregated for many reasons. Examples include a prisoner who has been found guilty of breaking discipline rules or if a prisoner's behaviour is so disruptive that keeping them in their normal location may be unsafe. A prisoner can also be held in the segregation unit for their own safety if they are threatened by other prisoners. This should only be

considered as a last resort when a specialist or vulnerable unit is not available.

Her Majesty's Chief Inspector of Prisons (HMCIP)

16. The most recent inspection of Pentonville by HM Chief Inspector was announced and took place in May 2009. With regard to bullying and violence reduction, she wrote,

> "Many prisoners felt unsafe. Violent incidents associated with trading in drugs and mobile telephones had been identified as a concern and efforts were being made to address this…Vulnerable prisoners held on G1 [a residential wing] generally felt safe but there were concerns about the use of overspill facilities on A [another residential wing], which were not in use during the inspection"

17. Whilst inspecting the procedures surrounding self harm and suicide, HM Chief Inspector said,

> "There was awareness of the risk of suicide and self-harm in the early days of custody and an appropriate focus on high risk groups…Good management information was provided and action plans were regularly reviewed, but more could be done to learn from near fatal incidents. Some assessment, care in custody and teamwork (ACCT) procedures were good, and day care offered support to many prisoners, but care plans were poor and case management inconsistent. It was not always easy for prisoners to see a Listener or contact the Samaritans at night."

Independent Monitoring Board (IMB)

18. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and areas of concern.

19. The IMB is kept informed about events in the prison through a weekly newsletter and a monthly diary presented at its meetings. Board members also receive the minutes of team meetings, staff briefings, Head of Function reports, and other documentation which together provide a broad view of any new initiatives or problems. The latest IMB report covered the period from 1 April 2008 to 31 March 2009.

20. With regard to Safer Custody (the department responsible for the safety of prisoners who may be at risk of harming themselves), the IMB reports

> "The number of Listeners has been adequate, though their distribution within the prison has not always been ideal…

“The number of prisoners on open ACCTs has steadily reduced, almost certainly due to greater confidence in closing these documents. This has the positive effect of enabling better scrutiny of those who are truly at risk. There remain some concerns over the quality of record keeping, but regular post closure reviews may address these problems.”

KEY FINDINGS

21. The man was a 34 year old man, who arrived at HMP Pentonville on 9 October 2009. He was remanded and convicted at Magistrates Court and was awaiting sentencing for offences of criminal damage and trespassing with intent at the Crown Court.

22. Arriving at reception at Pentonville, the man was assessed and it was noted that he had become angry and aggressive at court. The Cell Sharing Risk Assessment (the CSRA is a document used to assess the risk of prisoners sharing a cell) noted that he had been on a constant watch at the Police Station as he had said he felt suicidal and was at risk of harming himself. Information from him suggested that he had previously tried to take an overdose and to hang himself. Also noted on the CSRA was that he had been diagnosed with bi-polar disorder (this is a condition in which a person has abnormally elevated or depressed states of mind which affects their ability to function normally). He had experienced a death in the family recently and was finding it hard to cope. Staff had concerns about him sharing a cell, as he could become angry and frustrated quickly and had a history of violence.

23. The man was also seen by Nurse A for an initial health screening. The nurse noted that he had a history at harming himself and attempted an overdose eight weeks earlier. However, it was also noted that he had no thoughts of harming himself at that time. The nurse said that the man had an 'unspecified bipolar affective disorder' and had been receiving venlaflaxine (an anti-depressant) 75 mgs daily to manage his depression. He was referred to see the doctor and the mental health team, for an assessment.

24. Next, the man was seen by a locum doctor, who signed into the electronic records system using a nurse's log in. The doctor wrote that the man had a manic depressive disorder and should be prescribed venlafaxine to be taken once a day. It was again noted that he had been referred to the mental health team.

25. The man then had a first night interview with Officer A. The purpose of the interview is to collect information from the prisoner whilst telling them about the prison. He was asked for his next of kin details, and given the opportunity to make contact with his aunt by letter or telephone call. He said that he had been expecting to come to Pentonville and had been there before. He said he had no concerns about being there. He also said that he had harmed himself and had taken an overdose five months earlier. However he said he had no thoughts of harming himself at that time. He also repeated that he had been diagnosed as bi-polar. The officer explained the induction process to him and gave him a copy of the induction booklet. He read and signed a violence reduction compact, which explained the behaviour expected of prisoners. He was given information about the prison and then located in a cell on A wing.

26. The next day the man was seen by Nurse B, a primary care nurse. The nurse noted that he was receiving venlafaxine for depression but had no thoughts of harming himself at that time. He appeared to be in a 'normal mental state'

and mentioned some dental problems for which he was referred to the dentist. The nurse also asked him for permission to obtain his medical records from his doctor in the community. However, he did not give his consent. He also signed an in-possession medication compact, which allowed him to keep the venlafaxine in his cell.

27. The mental health referral made during reception was received by the mental health team on 12 October. It was reviewed by a forensic community psychiatric nurse . She noted that there was no known history of mental illness and tried to contact the man's aunt for further information. However she had no response. (It is unclear, given that he refused to give his consent for his medical records to be obtained, why these enquiries took place.)

28. On 13 October, the mental health team discussed the man at their team meeting. They planned to contact the hospital for information, as he had been admitted to mental health units at least three times before, most recently in July 2009. (He had also had treatment from the Community Drug and Alcohol Team, Crisis Resolution and Home Treatment and as an outpatient.) He was described by the hospital as having a long history of drug abuse including crack cocaine and heroin. A history of depression, including a previous suicide attempt by hanging during another term of custody at Pentonville, was also noted. He had also been prescribed mirtazapine and venlafaxine (both anti-depressants) during 2009, and was given an initial diagnosis of Emotional Unstable Personality Disorder.

29. Two days later the man was seen by a triage nurse, but no reason or further information is recorded. Four days later, on 19 October, he saw Prison Doctor A complaining that he was having difficulty sleeping. He was prescribed three zopiclone tablets (zopiclone is a treatment for insomnia), once to be taken each night.

30. On 21 October, a healthcare worker rang the man's aunt to ask her about the bi-polar disorder and for any other relevant information. She noted in the medical records that he had been diagnosed with bi-polar and gave the name of the doctor and consultant he had been seeing. His aunt said that he had a care worker and that she would supply details later that day.

31. Five days later, during a meeting on A wing, it was discussed whether the man could work as a cleaner. No concerns or objections were raised.

32. On 28 October, a member of the mental health team, attempted without success to make contact with anyone identified from the information that the man's aunt had provided. He left a message asking her to ring him back. The aunt returned the telephone call the next day and gave the telephone and fax number for an assessment unit. The mental health worker rang the unit and spoke to someone who confirmed that they knew the man and agreed to fax the information they held. The mental health worker noted in the medical records that the information was received the same day. (However, the information was not passed on by him or recorded on the electronic records system. He put the fax in his desk drawer, where it remained until 18

January, and was not discussed or assessed at any team meetings. During his interview for this investigation, he attributed his action to a training need as he had not been given formal induction for the job.)

33. The fax was from the Mental Health Assessment Unit at the hospital. It confirmed that the man was an in-patient there from 29 to 31 July 2009, following an assessment by his doctor in the community. He had been admitted to the unit previously in April 2009 and to another ward the following month under the care of a consultant psychiatrist with a diagnosis of mental and behaviour disorder.

34. The information from the hospital went on to say that during an assessment on 30 July, the man told a doctor and staff nurse that he had been admitted because he felt very low and suicidal. He had been arguing more with his girlfriend of eight years and so she had broken up with him. He had been unable to sleep and had started to use crack cocaine and heroin again. However, he said he realised this was the wrong thing to do and had thrown some of the drugs away. He said he had stopped taking mirtazapine three weeks earlier as it was causing drowsiness. He also said that his 11 year old daughter was his "inspiration to live" and that she lived with her mother in London. He said that he wanted to continue to take mirtazapine, but in a soluble form.

35. Following an assessment by the psychiatrist the next day, it was planned to discharge the man, with a follow up by the unit. He was given an appointment to attend an outpatient unit in six weeks time. The plan was to refer him for psychotherapy and replace the mirtazapine with venlafaxine XL. He was discharged from the unit later that day, diagnoses as an emotionally unstable personality disorder.

36. The prison mental health worker then received detailed information about the man's admittance to the unit earlier in the year (in April 2009) which occurred after he was assessed by an out of hour's forensic medical officer at the Police Station. The doctor recommended a further mental health assessment as the man had been depressed and had ideas of harming himself. It was noted that he had a history of 'adjustment disorder' (which is brief depressive symptoms and mental and behavioural disorder due to the harmful use of cannabis). The notes also contained more detailed information about him. However, this information was not passed on by the mental health worker.

37. Over the next few weeks in prison, the man saw members of healthcare for a hepatitis B vaccination and shoulder pain due to heavy lifting. On 19 November, the mental health worker telephoned the Community Team at the hospital again. This time he established that the man had neither been on the Care Programme Approach (CPA) nor been allocated a community psychiatric nurse. This contradicted the information previously given to him.

38. It was not until 25 November that the man attended a meeting with the mental health worker, almost seven weeks after the referral. (A meeting planned for 17 November had been cancelled by the man as he had a family visit.) They

discussed his mental health history and drug use, confirming that he was due to attend court on 14 December. He requested a referral for bereavement counselling as his father had died suddenly from a heart attack and it was he who discovered him. He said he had not recovered from the traumatic incident. It is clear that neither a formal assessment of his mental health nor a risk assessment was carried out at this stage. During his interview for the investigation, the mental health worker said that this was not normal practice and, in his previous post, an assessment would have been carried out prior to a meeting.

39. On 20 November, the man saw a doctor and complained about shoulder and neck pain which he attributed to heavy lifting in his job in the kitchen. He was prescribed ibuprofen gel.

40. A note in the wing observation book on 25 November, (the signature of the officer who made the entry is illegible) said that the man had mentioned that he had problems with some prisoners on D wing because he had got into debt through borrowing tobacco. He had been told he had to pay back his debts to avoid being beaten up. He thought this problem would be resolved if he moved from C to E wing, as he had friends and relatives there who would look out for him. (It is unclear when he moved from C to E wing, but no problems with prisoners were subsequently recorded.)

41. On 3 December, a fax was sent to the prison from the man's solicitor. They wrote that the prison had informed them that he had received some treatment by the mental health team and asked for details of their prognosis. A reply was sent the same day, explaining that he had been referred to the prison's mental health team and the mental health worker had been allocated the case. He had contacted the man's relative and community drug and alcohol teams to confirm any diagnosis and treatment. It confirmed that he had not had a community psychiatric assessment and therefore did not require an allocated worker from the mental health team. The letter also said that he was currently being monitored at a weekly healthcare meeting. It added that he did not require assessment by the psychiatrist and no further concerns had been reported.

42. Although it is difficult to ascertain the date from prison records, it was around this time that the man was sacked from his job in the kitchen and the wing servery. This was because he tested positive during a mandatory drug test.

43. On 6 December, the man was seen by a primary care nurse following an altercation with another prisoner. He said he had been on his bed in the cell and had been attacked, hit and scratched. He sustained bruising and cuts and the nurse gave him a tetanus vaccination. He was then taken to the segregation unit. Whilst he was there he was seen by a nurse and three doctors, but no concerns were raised at any time.

44. The next day, on 7 December, the man applied for Rule 45 status. (A prisoner can apply for Rule 45 if they feel vulnerable or threatened. They can then be moved to a unit with other vulnerable prisoners.) A vulnerable

prisoner assessment was carried out by a member of staff. The cause of his request was that he felt threatened by other prisoners, and he had been attacked twice in two days by different prisoners as he had got into debt through borrowing tobacco. It was noted that he had already moved wings once for this reason (from C to E wing) and now agreed to move to G wing. He was not to be left unattended with other prisoners from other wings. It was agreed that he should have vulnerable prisoner status and locate to G wing, but that consideration should be given to transferring him to another prison in London. It is unclear from prison records when he was moved from the segregation unit onto G wing, but, by 9 December, he had certainly been located once again in the segregation unit, as he had been fighting with another prisoner (he remained there until 13 December).

45. The man met with the mental health worker on 15 December. This appointment seemed to follow a similar pattern to their previous meeting and consisted of a general discussion rather than any formal review of his mental state or risk factors, although the mental health worker noted that he did not have any intention of harming himself. No notice seems to have been taken of the fact that since his last review, he had lost his job (as he produced a positive drug test) and had two altercations with other prisoners, one of which had resulted in him being located in the segregation unit. The plan was for him to be reviewed by the mental health worker in a month's time and he was referred for bereavement counselling (he had previously requested this on 25 November).

46. There is a note in the man's medical records that he was seen by a triage nurse on 29 December, and that the appointment was marked as being urgent. However no further information about this appointment was available.

47. On 5 January 2010, the man's cell mate raised an alarm. Officer B said that she and another officer attended the alarm bell in his cell on G wing. They found that he had made a ligature from his bedding which he had attached to a window, although he had not tied it to his neck. However, he was lying in the top bunk bed with his head in his arms and was visibly distressed. His cell mate had raised the alarm as he had awoken to see him doing this. While the other officer cut the ligature, she spoke to him. At that point he seemed less upset and was able to answer questions about how he felt. She opened an ACCT as a means of providing additional monitoring and support for him at this time. She recalled that he seemed subdued, but not tearful. She noted that he was not taking his medication, that it was a family member's birthday the next day, that he had hoped to have become engaged in July and that he thought his family were no longer interested in him. They discussed his bi-polar disorder and he said that he had missed a medical review that morning. (A note in the wing observation book said that he had become agitated as the doctor was late and consequently only had time to see three or four prisoners.) It was agreed that he would be observed by staff hourly. It was noted in the ACCT that he seemed very upbeat that evening and was seen talking and laughing with other prisoners.

48. The next day the man had an ACCT assessment interview, the purpose of which was to obtain further information and assess his risk to himself. He said that he had acted the way he had due to a build up of stress. He said he was waiting to be sentenced which was causing him stress and he felt his medication was not helping him. He added that at times he felt he had no reason to live, but then remembered his child. It was agreed that he should inform staff when he felt his mood changing and he should apply to be a Listener, a role he had carried out before. A review of the ACCT was scheduled for 13 January. He was also seen by Prison Doctor B for insomnia. The doctor prescribed a further course of zopiclone.

49. Also on 6 January, a meeting took place between discipline staff and the mental health team. No concerns were noted, even though an ACCT had been opened the previous day.

50. Later that day, it was recorded that the man had a fight in the showers with a prisoner from his wing. The fight was broken up and he returned to his cell. He then had a fight with his cell mate, who said that he had thrown a chair at his head. He said it was he who had been assaulted and he appeared to be emotional. He was seen by a nurse who noted he had not sustained any wounds or injuries. It seems that other prisoners on the wing took exception at his assault on his cell mate. The duty governor was informed about the assaults and that the man was on an open ACCT. He considered all of this and decided that the man should be moved to the segregation unit, partly for his own safety. He was taken there in a very distressed state, crying and shaking and was then allocated a cell. There were no safer cells (cells without any ligature points) free at that time. Senior Officer (SO) A spent some time talking to him and attempting to calm him down. He asked him to help move some lockers with him, in an attempt to distract him, which seemed to work.

51. The man was assessed by a mental health nurse shortly after arriving in the segregation unit. The purpose of the assessment was to ascertain whether he was fit to be located there. During her interview for this investigation, she said she recalled that she sat with him on his bed and discussed how he was feeling. He said that he wished he could see his family. She was only then became aware that he was on an open ACCT and subject to hourly observations (she was not aware that anyone from health care had been informed or invited to attend ACCT reviews). She knew that prisoners in the segregation unit were checked more frequently (every half an hour) and she did not think he would harm himself as he did not seem to have any active plans to do so. (Although she did not make a note of this, she recalled speaking to a doctor from the mental health team the next day to inform him that the man was now in the segregation unit. She said that the doctor told her he required a written referral before acting on this information. She said that he did not need one, but the doctor replied that he was new and did not know the process).

52. The man saw Prison Doctor C in the segregation unit the next day. He asked for sleeping pills and told the doctor that venlafaxine was not working. The

doctor noted that he had been prescribed zopiclone but would not have yet received it, and requested that his case should be discussed by the mental health team. However, no referral appears to have been made. Another entry in the medical records noted that he was discussed at the wing meeting. Staff discussed his coping mechanisms and his care plan whilst he was on an ACCT.

53. Also on 7 January, the man was seen by a senior officer in relation to violence reduction, as there was a strong suspicion (given the altercation with his cell mate the previous day) that he was involved in violent and anti social behaviour. A form was given to him, which said that this behaviour would not be tolerated and he would be reviewed after 28 days.

54. The man asked another SO in the segregation unit, SO B, to ring his solicitor to try to find out his court date. She did so and told him he was on the warning list (his case was due to be heard) for 11 January. He told her he was pleased to hear that. He added that he thought he was looking at a six month sentence and, as he had already served five months, he was looking forward to being released soon.

55. On the morning of 8 January, the man attended an adjudication hearing for the assault against his cell mate. He said that he had not assaulted him but had been subjected to an unprovoked attack and was defending himself. He requested legal advice and the hearing was adjourned. Officer C took him back to his cell and he became abusive towards her. A few minutes later he rang his cell bell and apologised to her when she attended. Lunch in the segregation unit was served to prisoners at approximately 11.45am. At around 12.20pm, the doctor carrying out his rounds in the segregation unit saw him. No issues were noted or recorded.

56. The man was due to be checked at 1.00pm, 40 minutes after he was last seen by the doctor. (Prisoners are on 30 minute observations when they first arrive in the Unit, thereafter the checks are hourly, unless more frequent observations are required.) SO B looked through the observation panel of his cell and could not see him at first. She then saw him lying by the sink, which seemed unusual. She quickly realised that he had a ligature around his neck which seemed to be attached to a tap on the sink. As other staff on the Unit were having their lunch in an office close by, she called out for assistance.

57. SO B opened the cell door and almost immediately SO A, Officer D and Officer E arrived. The officers could see that the man had made a ligature from a green bed sheet and tied it to the tap. Officer E lifted him as he was slumped in the floor and SO A removed the ligature by cutting it with Officer E's anti-ligature knife.

58. Whilst this was happening, Officer F, who had also been taking her lunch break in the office nearby, rang the prison's alarm bell. She said that she raised the alarm that way, rather than radio through a medical emergency, as she heard a level one call (the prison's emergency call to alert staff to an

incident) and knew somebody else had already done this (it is not clear who this was).

59. SO A recalled that the man appeared unresponsive, although both he and SO B thought they had heard a gasp of breath from him. He pinched his ear lobe and called out to him. He felt for a pulse, but found none. Officer D also felt the man's wrist and neck for a pulse. SO A immediately tilted the man's head back to clear his airway, whilst Officer D got into position to commence chest compressions.

60. Officer D began to carry out chest compressions immediately, whilst SO A went to get a mask to place over the man's mouth so he could commence mouth to mouth. He had difficulty doing this as there appeared to be a lot of fluid around the mouth which made it difficult to get a good seal around it and administer air into him.

61. Nurse B, who had heard the emergency call over the radio in healthcare arrived very quickly and took over administering mouth to mouth from SO A. She confirmed to my investigator that the man had fluid around his mouth which made this difficult. She also said that that she could not detect a pulse and no cardiac output. She said his skin appeared to be mottled and there were signs around his face that he was cyanosed (a blue discolouration of the skin due to lack of oxygen). Other healthcare staff arrived at the cell very quickly and brought with them emergency bags of equipment, oxygen and a defibrillator. She used a bag value mask attached to an oxygen cylinder to administer air, and also attached the pads of the defibrillator to his chest. The machine said there was no shockable rhythm (this means that the heart could not be shocked back into rhythm). The nurse and Officer D continued to attempt Cardio Pulmonary Respiration (CPR) at a rate of 30 chest compressions to every two breaths. Officer Greiner E over chest compressions from Officer D when he became tired.

62. Nurse B tried to establish an intravenous line in order to administer medication, but was unable to do so. She continually monitored his blood pressure and suctioned the man's mouth to remove fluid. The other nurses in attendance assisted her who continued CPR with Officers D and E. Prison Doctor D came to help but left the cell to ask for an emergency helicopter to be called (the Helicopter Emergency Medical Service – HEMS).

63. At approximately 1.13pm, three paramedics arrived at the man's cell. They assessed his condition and continued with CPR and advance life support. They successfully set up intravenous access to administer medication and gave him adrenalin injections. They used their own defibrillator to determine whether they could shock his heart into a rhythm. Once again, the defibrillator said there was no shockable rhythm.

64. The paramedics said that the man had fractured his larynx, which was causing difficulty in administering air, but continued with CPR. At approximately 1.45pm, the air ambulance crew arrived with two doctors. They carried him out onto the floor of the Unit, to allow them more room. Closed

Circuit Television (CCTV) footage given to the investigator clearly shows this and the paramedics attempt at resuscitation. A member of staff covered up the observation panel of a cell close by, to shield the prisoner from what was happening. Other officers can be seen attending to cell bells throughout, and explaining to other prisoners on the segregation unit what was happening.

65. The air ambulance crew continued CPR until1.53pm, when one of the doctors pronounced the man dead. Staff members moved him back in to his cell and placed him on the bed. An officer was asked to sit outside the cell door until the police arrived.

66. Staff were told to wait in the Adjudication Room for a hot de-brief (a meeting where staff have the opportunity to talk about what happened and how the emergency was handled). When it became apparent that the room was too small for so many people, they re-located to the boardroom. Care team members also attended the meeting (they had also been present in the segregation unit beforehand) and spoke to staff, in particular those who seemed distressed.

67. SO A returned to the segregation unit and ensured that all the prisoners there were put on half-hourly observations and all ACCT documents were reviewed. He also spoke to staff and told them that they could go home if they felt unable to complete their shift and he would arrange taxis for those who did not feel able to drive home. He met with the police when they arrived and helped them gather paperwork and copies of the CCTV footage. Notes written by the man to his mother and a friend were found in his cell and also passed to the police. They expressed his despair at life and how he was going to see his father (who had died). The SO said that he felt very upset himself at this point, and very disappointed that they could not resuscitate him, but that he preferred to stay on duty.

68. A governor at the prison was appointed as the prison's family liaison officer. He asked the police who were still in attendance there to make arrangements for officers to accompany him when he broke the news of the man's death to his family. He and a chaplain left Pentonville at approximately 6.30pm to travel to the Police Station. There they met with three police officers (two female officers) and they all went to the man's aunt's address. In the presence of the police officers, the chaplain told her that the man had died. He and the prison's family liaison officer explained what had happened and gave her information regarding bereavement agencies and the coroner's role. The family liaison officer gave her his contact details and told her to get in touch if she needed to speak about anything or wanted to visit the prison.

69. On 18 January, ten days after the man died, the mental health worker forwarded all the information he had acquired for the man for scanning into the medical records. This is the first time this information had been seen by any other member of staff.

70. A critical incident de-brief was held approximately two weeks after the man had died (although nobody the investigator spoke to could recall the exact date). Most staff said they found the de-brief helpful.

71. The man's funeral was held on 2 February. His family wanted only family and friends to attend, and therefore declined the prison's family liaison officer's offer to represent the prison. The prison arranged to pay the cost of the funeral in full.

72. The post-mortem report, received after the draft report had been issued and the inquest had taken place, indicated that the man had alcohol in his blood. This was especially unusual as he had been located in the Segregation Unit prior to his death. Despite enquiries at the prison by interviewing Segregation staff and looking at local practices and procedures, the investigator was unable to establish how this could have happened.

ISSUES

Opening an ACCT

73. The man's attempts at harming himself were clearly documented when he arrived at Pentonville. The nurse who saw him on reception explored this history and his mental health issues. Although a referral was made for him to be assessed by the mental health team, no ACCT was opened at that stage.

74. It is difficult to make a judgement about whether this was the right decision, as the nurse used her professional skills to determine whether he should be monitored by the ACCT process. He told the nurse he had no thoughts of harming himself at that time, although he did mention his previous attempts, that he had suffered bereavement and had been diagnosed with bi-polar disorder. However, he was located in the First Night Centre and received an induction, and his first two months at Pentonville passed without incident. Given this, I do not make a recommendation, although the Governor might wish to remind staff that when a prisoner has a history of harming themselves, they should consider whether an ACCT should be opened. If they then believe that an ACCT is not necessary at that time, the reasons for this should be clearly documented.

Information not shared with the mental health team

75. A mental health worker was appointed as the man's key worker although this was not noted on the electronic medical records. He did not record that he obtained background information regarding the man's previous mental health assessments from outside agencies. It appears that he put the information in his desk drawer rather than share it with any other member of the team, and therefore the man was not discussed or assessed at any team meetings. The mental health worker attributed this to being new to his job and a lack of training.

    The Head of Healthcare should ensure that all staff are aware that all information regarding patient care should be placed immediately onto the Electronic Patient Record.

76. In particular, the Head of Healthcare should review the team's communication system to ensure that relevant clinical information about a prisoner is made available to all the staff who require it.

    The Head of Healthcare should carry out a review of the team's communication system to ensure that all relevant clinical information about a prisoner is made available to all staff who require it.

Delay in a mental health assessment

77. It took seven weeks from the time the man was received at Pentonville, to attend his first face to face mental health appointment with the mental health worker. (However, it should be noted that an appointment for 17 November

was cancelled by the man as he had a social visit that he did not want to miss.) From medical records and from the interview with the mental health worker, it seems that a general discussion was held about the man's previous contact with mental health services, his drug use and family history of mental health issues. It is clear that at this time no formal assessment of his mental state or risk assessment took place.

The Head of Healthcare should ensure that minimum standards are set and monitored from a prisoner's first assessment to their first appointment with a member of the mental health team.

78. Further, the mental health worker was not aware at the time that a formal examination of a prisoner's mental health was required on allocation to a mental health worker.

The Head of Healthcare should ensure that all patients assessed by the mental health team should have a full mental state examination and risk assessment and this should be clearly recorded on the electronic medical records.

Failure to assess the man following location in the segregation unit

79. On 6 December, the man was seen by a primary care nurse following an altercation with another prisoner. She noted a number of minor wounds and gave him a tetanus vaccination. He was then located in the segregation unit, where he stayed until 13 December, being seen daily by healthcare staff. It is unclear why this event did not trigger a further assessment by the mental health team. As a patient of the team it seems reasonable that an admission the segregation unit should trigger an automatic review.

The Head of Healthcare should ensure that a system is in place to trigger an automatic mental health review for a prisoner if they are known to the mental health team and admitted to the segregation unit

Was it appropriate to move the man to the segregation unit?

80. Given the man's history of harming himself, his recent attempt to harm himself in prison two days beforehand and his mental health issues, it is important to consider whether it was appropriate for him to be located in the segregation unit.

81. The man was on an ACCT when he went to the segregation unit and the staff were aware of this. He had an outstanding adjudication as it was alleged that he assaulted another prisoner, and he had already had two altercations that day. As he would have been observed as frequently in the unit (if not more so), that staff were aware of him and his issues and could monitor him closely and that a member of healthcare visited the prisoners in the segregation unit daily, it does not seem that he would have been at greater risk there. However, it should also be noted that it was his cell mate who alerted staff to his previous suicide attempt and that being in a single cell in the segregation

unit may have given him the opportunity to harm himself. I make no recommendation here, as procedures were followed correctly and he was assessed by a nurse when he arrived in the Unit. However, staff should be aware that vulnerable prisoners who are located in the segregation unit may need additional monitoring and support. On this occasion, he seems to have been well supported by staff there, in particular by SO A.

Delay in referral for bereavement counselling

82. Medical records show that the man requested bereavement counselling during a meeting with the mental health worker on 25 November. It appears that this request was not actioned, as another note in the records (dated 15 December) says that he was referred for bereavement counselling, some 20 days after he requested it. Given that he had been clearly distressed about the loss of his father, and this continued to play on his mind, a more urgent referral should have been made.

    The Head of Healthcare should ensure that a prisoner's request for bereavement counselling is actioned as soon as possible.

Involvement of the mental health team in ACCT reviews

83. An ACCT was raised for the man on 6 January 2010. However, no member of the mental health team had any knowledge of this and the mental health nurse only became aware when she visited him in the segregation unit.

    The Head of Healthcare should review how and when healthcare becomes involved in the ACCT process, particularly for prisoners who are known to the mental health team.

Family being unable to contact anyone at the prison on New Year's Eve

84. The man's family spoke about receiving a worrying telephone call from him on New Year's Eve. He had seemed very distressed and spoke of wanting to end his life. They immediately tried to make contact with a member of staff at the prison, but were frustrated that they were unable to speak to anyone. It is unclear whether they spoke to staff on the switchboard, or got through to the control room out of normal working hours. The call was passed to various departments, including the Chaplaincy and the Governor's office, with no reply. The family attributed this to low staffing levels on New Year's Eve and were relieved when he telephoned them back to say he had just been silly and was feeling okay.

85. However, there should be some way for members of the public to contact the prison at any time if they have concerns, regardless of the time of year or whether it is a holiday period or outside of normal working hours. As there is always a governor on duty (the duty governor), staff on the switchboard or in the control room (whichever receives the telephone call) should ensure the call, or a message for the call to be returned urgently, is passed to the duty governor.

The Governor should remind staff who answer telephone calls from the public that in the event of an emergency the duty governor should be located and informed about the call.

CONCLUSION

86. The man was a young man with a history of mental health problems. These, along with his behaviour and attempts to harm himself were well documented at court and at the police station were he was held.

87. Although these issues were highlighted when he arrived at Pentonville, an ACCT was not raised for him at the time, as he said he had no current thoughts of harming himself or of suicide. This is clearly at odds with the information gathered about him from various sources. However, a referral was made for him to be assessed by the prison's mental health team.

88. The man was appointed a key worker who began to contact various agencies who had dealt with him, for further information. Unfortunately he did not pass on this information to anyone else in his team or enter it on the electronic medical records system, but left the information in his desk drawer. He attributed this to lack of training for the job. Although this is quite clearly neglectful, it is impossible to be sure that this had an effect on the man. It is also unfortunate that his request for bereavement counselling was not actioned when he initially requested it, but again it is not possible to say whether this had an effect on the decision to take his life.

89. Staff in the segregation unit appeared to try to engage with the man and SO A, in particular, spent time talking to him and trying to distract him by asking him to help out with various tasks. He was monitored and observed closely by staff, but his behaviour remained volatile and unpredictable.

90. The staff who discovered the man in his cell worked tirelessly to try to resuscitate him, as did the paramedics and doctors who arrived very quickly afterwards. Sadly they were unable to resuscitate him.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all staff are aware that all information regarding patient care should be placed immediately onto the Electronic Patient Record.

   Accepted – All staff have now been instructed that any patient based information received must be scanned onto the electronic patient record.

2. The Head of Healthcare should carry out a review of the team's communication system to ensure that all relevant clinical information about a prisoner is made available to all staff who require it.

   Accepted – All patient records are subject to regular audit checks. The staff are aware that ALL contact and information must be scanned immediately to the electronic record. A review of how well the healthcare teams are communicating is to be completed and form a clear strategy produced to clearly set the standards expected.

3. The Head of Healthcare should ensure that minimum standards are set and monitored from a prisoner's first assessment to their first appointment with a member of the mental health team.

   Accepted – The Mental Health Team now have a policy in place and operational that ensures every referral is screened within four days. The referrals classed as urgent are reviewed within 24 hours. Training on mental state examination is being undertaken by the lead for mental health to ensure all primary care staff can carry out an MSE at all times. This training will be completed by end October 2010.

4. The Head of Healthcare should ensure that all patients assessed by the mental health team should have a full mental state examination and risk assessment and this should be clearly recorded on the electronic medical records.

   Accepted – The Head of Healthcare has met with the MHT and lead clinicians to ensure that all staff understand the need to clearly document a clear initial assessment (MSE). It is understood and accepted that all MSE's must also contain a clear assessment of any risk in relation to the patient's mental state and this should include assessment of any previous history and the impact on current mental health.

5. The Head of Healthcare should ensure that a system is in place to trigger an automatic mental health review for a prisoner if they are known to the mental health team and admitted to the segregation unit.

   Accepted – Head of Healthcare to ensure clear policy in place that instructs all healthcare staff to ensure the MHT are aware of their patients when admitted to the Segregation Unit. This is to include electronic alert

being placed on EMIS to ensure the MHT patients can be clearly identified by all healthcare staff.

6. The Head of Healthcare should ensure that a prisoner's request for bereavement counselling is actioned as soon as possible.

Accepted – Head of Healthcare has requested that lead for therapies and Mental Health Team review current referral and response process. They are to report back in August 2010. System to be in place September 2010.

7. The Head of Healthcare should review how and when healthcare becomes involved in the ACCT process, particularly for prisoners who are known to the mental health team.

Accepted – Currently all reviews for ACCTs in Segregation and Healthcare Inpatients are carried out by a multi-disciplinary panel. A format is to be agreed with residential staff that healthcare will provide an ACCTs representative to all ACCT reviews across the prison. This will be a whole healthcare response and all staff groups will be used to ensure compliance with this recommendation.

8. The Governor should remind staff who answer telephone calls from the public that in the event of an emergency the duty governor should be located and informed about the call.

Accepted – Instructions have been issued to all switchboard staff that if a caller raises concerns regarding a prisoner, that the call is put through to the Duty Governor or the Orderly Officer who will take appropriate action.