PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man whilst in the custody of HMP Pentonville in August 2010

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is the report into the troubling circumstances of the death of a man whilst in the custody of HMP Pentonville in August 2010. He was found in his cell in the healthcare centre on 4 August with a plastic bag over his head and a belt round his neck. He was taken to hospital but did not regain consciousness. He died two days later after the life support ventilator was turned off. He was 27 years old.

I would like to offer my condolences to the man's family and friends for their loss. A key objective of all of my investigations is to ensure that the bereaved family has the opportunity to raise concerns, and contribute to the enquiries. One of the office's family liaison officers spoke with the man's father and his uncle who raised a number of questions and provided useful background about him. I trust the investigation provides answers these questions. It is with regret that the report has been severely delayed as a result of a late clinical review and workload pressures in this office. I offer my sincere apologies for this.

The investigation was initially investigated by my colleague before being transferred to another investigator. I would like to thank the Governor and staff of HMP Pentonville for their co-operation with the investigation. The local PCT commissioned a review of the medical care that the man received in custody. A clinical reviewer was appointed to undertake the review.

At the end of July 2010, the man became involved in a fight with another prisoner and was segregated. Whilst in the segregation unit, he thought prisoners believed him to be a sex offender and that staff encouraged prisoners to attack him. Two days after being segregated, he covered himself in his own faeces, cut his arms and armed himself with two wooden table legs. After staff intervened using force, he was assessed by a psychiatrist and relocated to the healthcare centre. Despite having cut himself, he was not placed on formal suicide prevention measures.

The attending doctor's request for a urine sample to detect any psychosis inducing drugs was not carried out. For reasons that have not been satisfactorily explained and against policy, the man's plastic bag of possessions, which included a belt, was left in the cell with him. He was observed at regular intervals during the night. The chaplain spoke to him at about 9.05am. Twenty minutes later, he was found with a belt around his neck and a plastic bag over his head. After efforts to resuscitate him, he was taken to the local hospital where he was put on a life support machine for two days. However, the machine was switched off and he died. His family were at his bedside.

The report examines a number of areas of concern regarding the man's treatment and makes consequential recommendations. In particular, I am concerned by the lack of formal suicide prevention measures that were applied and the failure to remove possessions with which he subsequently took his life, together with issues about staff training and information sharing. I hope and expect that the lessons arising from this tragic case will be learned.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2012**

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SUMMARY

1. The man was arrested on 6 July 2010, nearly a year after he allegedly committed two counts of grievous bodily harm. He had apparently spent the last year 'on the run' and had lost a significant amount of weight. He appeared at Magistrates' Court and was remanded to HMP Pentonville.

2. On 24 July, he received medical treatment for a cut on his head following a disagreement with another prisoner while using the telephone. With the exception of this incident, he did not come to staff's attention until 29 July when he punched another prisoner who he believed had called him a "racist". Wing staff asked the mental health in-reach team to see him and they concluded that he did not have a mental health problem.

3. During the afternoon, two applications were found by wing staff in the applications box suggesting that there was a serious threat to the man. These were not shared with him at any time. On 31 July, following an adjudication, he received seven days segregation for the fight two days earlier and was held in the segregation unit.

4. On 1 August, in the morning, the man telephoned his father twice and said that officers were showing people his file and saying that he was a 'nonce, racist and police informer'. He also said that they will be "getting him" when his father visited on 4 August. On 2 August, he was seen by the officer investigating the racial incident on 29 July who did not have any concerns about his state of mind. Later that day, officers from the segregation unit contacted the mental health in-reach team as they had concerns about his paranoid behaviour and the doctor on the segregation rounds also referred him.

5. The man made two further calls to his father that day, both times saying that officers were encouraging prisoners to rape him and that he was being "stitched up". At 11.00pm, he covered himself with excrement and made a weapon from a table leg. After speaking with staff during the early hours of the morning, he cleaned himself but again at 4.50am continued to make threats to staff and covered himself again with excrement.

6. Throughout the morning, he maintained his protest and would not give up the weapon. At 2.00pm, a planned intervention took place with staff in control and restraint gear entering the cell and removing the weapon. He put up no resistance and no force was used on him. A forensic psychiatrist and a mental health social worker assessed him during this time. He had superficial cuts to his arms and said that he had cut himself "not to kill himself, but that nobody would grab him if there was blood on him". The psychiatrist explained that she would like to transfer him to healthcare for an assessment and he agreed to give a urine sample to a nurse but not an officer. Despite, at least eight members of staff being in the vicinity, none opened a suicide/self-harm monitoring document (known as Assessment, Care in Custody and Teamwork or ACCT).

7. At 4.40pm, discipline staff attempted to escort the man to healthcare. Upon leaving his cell in the segregation unit, he became non-compliant after staff refused to let him remove things from his property bag. Staff had to restrain him and take him to healthcare in cuffs. During this time, the plastic bag of possessions was dropped and nobody was able to recall taking it with them to healthcare.

8. Upon his arrival in healthcare, he was allocated a cell by a healthcare officer. Somehow, his bag of possessions was placed in the cell with him having not been risk assessed, in accordance with the unit's policy. Although staff on the unit were aware that the man was coming over for assessment, there is no evidence of a handover between segregation staff and healthcare staff.

9. He was briefly seen by a nurse who recorded that he was fine. Discipline staff tried to engage him in conversation but he was not forthcoming. During the evening, he spent a considerable time talking to a fellow prisoner (who worked as a cleaner on the wing) through his cell door hatch. The prisoner was concerned about him and what he was saying and expressed his concerns to staff on the unit.

10. The man was observed every half hour throughout the night (as is routine for all patients in healthcare) by two members of staff alternating the duty. He was described as noisy and disruptive until about 3.30am when he appeared to go to sleep. When staff came on in the morning, they took over the half hourly observations. At 8.30am, he was asked by the officer if he was okay, but did not reply. At 9.00am, he was seen stood at the back of his cell shouting "they're killing my dad". At 9.05am, the chaplain came onto the wing and the man called out to him through his door. He told him that "he would be dead by tomorrow". The chaplain said that he spoke with the staff and they all thought he was paranoid or speaking for effect.

11. At 9.13am, the man's father was booked into the visits hall for a pre-arranged visit. Healthcare had not been made aware that he was there. At about 9.30am, an officer went to check on him again and saw through the hatch that he was on the floor and not breathing. He opened the door and blew his whistle. He had tied a belt round his neck and placed a bag over his head.

12. No pulse was found and staff attempted resuscitation. Paramedics arrived at 9.50am and jugular vein pressure could be seen indicating that the heart was beating. The man was taken to hospital but did not regain consciousness. His ventilator was turned off at 7.00pm with his family at his bedside.

13. I make ten recommendations including guidance and training around ACCT, completing relevant documentation and undertaking consistent risk assessments in relation to property for prisoners in the healthcare unit.

THE INVESTIGATION PROCESS

14. An investigator was appointed to investigate the man's death. She visited HMP Pentonville on 10 August 2010 to open the investigation. She met a number of senior managers including the Deputy Governor, the Deputy Head of Healthcare, and the liaison officer for the investigation, and a Governor who also acted as the prison's family liaison officer.

15. During her opening visit the investigator was shown around the prison and spoke to staff on duty. She met a friend of the man's, another prisoner, and had a brief conversation with him. She collected a copy of his available prison records and arranged for further records to be collated for the purpose of this investigation.

16. The investigator attended the Coroner's court on 12 August and met the man's sister and uncle. She briefly explained the role of the investigation and told them one of the office's family liaison officers would be in contact to listen to any concerns that they had about his time at Pentonville. During the opening of the inquest, she agreed with the Coroner that she would co-operate with his officers' investigation and share statements where possible to avoid duplication. A copy of this report will be sent to the Coroner to help him prepare for the inquest.

17. The investigator returned to the Coroner's office on 23 August to review photographic evidence of the man's self-harm injuries. She arranged to meet the clinical reviewer, appointed by the local PCT, to discuss the medical care that he received at HMP Pentonville. They agreed to conduct joint clinical interviews.

18. On 1 September, the man's investigation was transferred to another colleague. The new investigator conducted 29 interviews with staff at Pentonville, some of which were joint interviews with the clinical reviewer. A key individual was unable to be interviewed as he was not working at the prison at the time.

19. The investigator was provided with an internal report by the local PCT and had many telephone discussions with the Deputy Head of Healthcare about their investigation and findings. In addition, verbal feedback was given to both the deputy Governor and Governor during and at the end of the investigation.

20. The investigator viewed the recording made of the planned intervention (when staff entered the cell to remove weapons from the man) and listened to the telephone calls he made to his father in the days prior to his death.

21. The investigation report is severely delayed. Quality issues were discussed at length with the clinical reviewer and the final clinical review was agreed in May 2011. The investigator also experienced ongoing difficulties getting the paperwork required for the investigation and arranging interviews with her liaison officer at Pentonville, which compounded the delay. Unfortunately, additional delays were caused by workload pressures in this office.

22. A family liaison officer spoke with the man's uncle who represented the family. The report addresses a number of questions he raised with him -

> Having been told by prison staff at the hospital that the man had self-harmed the previous day, the family asked what actions had been taken as a result.
>
> What actions were taken by staff after the prisoner spoke to them about his concerns about his well being?
>
> The family had been told that he had smashed up his cell and been moved. What exactly happened and where was he moved to?
>
> More information about the fight he had with another prisoner.
>
> How did he have access to a plastic bag and belt?

23. The draft report was advanced disclosure to the National Offender Management Service (NOMS) and their response can be found at paragraph 162. No changes have been made to the report as a result of their comments. NOMS accepted all the recommendations and the responses have been repeated verbatim in the recommendations sections.

24. The family received a copy of the draft report and asked for the following to be added to the final report

> "The family and solicitor have passed on their thanks to the Ombudsman's office for the investigation report. The man's sister explained that they found the report informative, distressing and alarming. She adds that the family were disappointed and angered with the care and management her brother received whilst in prison. She explained that the family and their legal representative will take forward their continued concerns at the inquest hearing."

HMP PENTONVILLE

25. Pentonville was built over 150 years ago and serves the London courts. It has an operational capacity of 1,250. This is the 18th death at Pentonville that my office has investigated since becoming responsible for investigating all deaths in prison custody since April 2004. There have been another five deaths since the man died.

Healthcare

26. A manager heads Pentonville's healthcare department, with three organisations providing health services. NHS Islington is the lead contractor and provides primary care services. Camden and Islington Foundation Trust provides substance misuse and mental health service (including the inpatients' unit) and Barnet, Enfield and Haringey Mental Health Trust provide psychiatric care.

27. The inpatient unit has 22 beds in total, with 12 beds on the east ward and 10 on the west ward. The west ward tends to accommodate those prisoners with physical problems whilst the east ward cares for those suffering with mental health problems. Each ward has a ward sister who is overseen by the ward manager who in turn is managed by the service manager for substance misuse and mental health. There is an Inpatient Care and Admission Policy, written in 2003, which outlines principles and procedures for all healthcare staff.

28. There have been two recent HM inspections of HMP Pentonville, one in May 2009 and the latest in Feb/March 2011. The most recent report said that 'all officers working on the unit were volunteers and the relationship between the patients and all staff was professional and congenial.'

Segregation

29. A segregation unit provides temporary accommodation for prisoners that have been violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners. A prisoner can also be held in the segregation unit if it is for their own safety as they may be under threat from other prisoners.

30. According to the Inspectorate's report, published in 2011, the segregation unit ran a basic but decent regime. All the prisoners spoken to who had been or were in the unit were positive about their treatment by staff there and the inspection team saw staff treating prisoners professionally and with respect.

Use of force

31. In relation to the prison's use of force record, the Inspectorate's 2011 report said that there were 285 incidents of use of force in 2010. All documentation was scrutinised by senior managers to establish whether force had been justified based on the accounts provided by staff.

ACCT

32. Assessment Care in Custody and Teamwork (ACCT) is the prison-service wide process for supporting and monitoring prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try and harm themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner.

KEY EVENTS

33. The man was arrested on 6 July 2010, nearly a year after he allegedly committed two counts of grievous bodily harm. Whilst in police custody, he was risk assessed for any indicators of self-harm, and for being under the influence of alcohol or drugs. No concerns were raised. He was described as asthmatic for which he had an inhaler although he declined to see the doctor in police custody for a health assessment. He appeared at Magistrates' Court on 8 July where he was remanded into custody until 15 July.

34. Following his court appearance, he was taken to HMP Pentonville at about 6.00pm. During the reception process, he said he was of no fixed abode and gave no next of kin details. He told the nurse on reception that he had no mental health problems and no thoughts of harming himself. The nurse referred him to see a doctor about his asthma, who he saw later that evening. The lead GP at Pentonville noted that he had his own inhaler. During interview, she said that she could not recall him in any detail. The doctor recorded that he needed no routine follow up. He was allocated to cell A2-24.

35. The day after the man arrived at Pentonville, another nurse carried out a secondary healthscreen. The nurse noted that his Body Mass Index (BMI) was normal and that he was a "light drinker". Again, it was recorded that he had no mental health problems and that he had no thoughts of harming himself.

36. The man had been in Pentonville on a previous sentence. Nevertheless, he would be expected to complete the prison's induction programme to remind himself of the rules and regimes of the prison. However, he refused to attend the second day of induction on 9 July.

37. On 12 July, a note was made on the man's case notes (an electronic record of each prisoner's time in custody) that he had been given until 15 July to find himself a cell mate, otherwise he would be allocated someone to share his cell with. An email was received in the custody office for him to appear at Crown Court by videolink on 15 July. There is no record of the video link hearing taking place or of the outcome of the court appearance.

38. The investigator met another prisoner, a friend of his and a prison listener. (A listener is a Samaritan trained prisoner who sees prisoners who are in distress or crisis and need to talk in confidence.) The prisoner said that he had known him since their school days and had previously been in prison with him. He said that the man had lost a lot of weight since he had last seen him "but he was fine in himself like, he was a bit stressed out obviously with his sentence but that was it." On 17 July, he was visited by his sister and on 22 July, his father and cousin visited.

39. On 24 July, at 12.15pm, it was recorded in his medical record that:

> "About 10.00hrs inmate was brought to the treatment room after sustaining a cut to the right side of his head following a fight with another inmate. Wound site was cleaned with normasol and sprayed with betadine. Steristrip was then applied as cut was superficial and then covered with mepore dressing. Analgesia was offered but inmate refused it. Observations done were as follow O/E – pulse rate 68 beats/minute."

40. This is the only record that the man had been in a fight. The prisoner said that he thought the fight had happened when the man was on the phone and another prisoner had tried to take the phone away from him. He was, however, moved to another residential wing, into cell G3-10.

41. On 26 July, an officer from G wing completed a Mental Health Referral Form. He wrote

> "The man stated he cannot share a cell because he <u>will</u> hurt his cell mate. He said he was talked into sharing a cell when he came in and didn't want to. He said he is becoming more and more stressed. His cell mate has now been moved and he feels much better."

42. That same day, a doctor chaired a routine weekly multidisciplinary meeting to discuss all mental health referrals and what actions were necessary. The team considered the officer's referral of the man and decided that it was not a matter for the mental health team. A note was made in his medical record to this effect.

43. A Community Psychiatric Nurse (CPN) in the mental heath team remembered the discussion in the meeting. She said during an interview with the investigator that the team's view is that, unless there is a previous mental health problem or the prisoner is particularly anxious, not wanting to share a cell is a prison concern rather than for the mental health team to consider. She said that her colleague rang the wing to try and speak to the referrer to explain the process, but he was not there so he spoke to someone else. She said that he would have been told that if things changed with the man or there was a mental health component that had not been mentioned on the referral form then they could reconsider the matter.

44. According to the visit log, the man was visited by his legal representative on the morning of 28 July.

<u>Incident on 29 July</u>

45. During association on the 29 July, at about 3.10pm, the man got into a fight with another prisoner. We understand from the prisoner that the man had previously been friendly with the prisoner. On this occasion, he thought he heard the prisoner describe him as a "racist", so he became angry and punched him. Staff became aware of the disturbance and Officer A stood in

front of him to keep him and the other prisoner separated. He was shouting "I am not a racist".

46. The officer walked him back to his cell and asked him what had happened. The man said that he did not like talking to officers about these things and just kept saying "no comment, no comment". The officer usually worked on the landing below so, although he was familiar with him, he had not had any previous dealings with him.

47. Due to the nature of the incident, the officer was required to complete a Racial Incident Reporting Form (RIRF) explaining what had happened during the incident. During interview, he said that, whilst completing this form, another officer gave him two applications which had been found in the applications box on the wing (prisoners place requests to see medical staff or other staff in a postbox). The first application said "get him out dead man walking". It was an application for healthcare with the reason for request was "stabbing". The second one was a routine prison application and said "get that nazi fuck out the jail or he's dead". A picture of a knife had been drawn on the application.

48. Although he could not be sure when these applications were placed in the box, the officer believed it must have had to have been prior to the man punching the other prisoner. He explained that everyone was locked up after the fight and so, in his mind, there would not have been any opportunity to submit the applications afterwards. The applications box is opened daily on week days (when the wing is fully staffed, if not then it could be every few days and usually at 9.00am and 2.00pm). The officer completed the RIRF including the details of the applications and passed it on to the race equality officer who investigates all RIRFs and prepares a report which is confidential and only seen by the Governing Governor of the prison. (This will be returned to later in the report.)

49. The CPN said that a senior officer phoned from the wing asking for the man to be seen as "he's been in a fight but he's quite strange…he just very, very quiet, not speaking to anybody, sitting in his cell and he has refused to see the general nurse to check over if he had any injuries so we actually responded immediately and went to see him". She explained that she and a colleague went in to speak to him and that he was "very pleasant and appropriate, engaging, willing to see us and we asked him about the incident and he actually said he regretted the incident".

50. The man told the two nurses that he had heard someone shout out "racist" and thought it was directed at him. As a result, he turned round and punched the person who was standing next to him. The CPN said they carried out a "mini mental state" asking him about previous contact with psychiatrists and drugs. He denied the use of drugs. He said that his sleep was quite poor but he thought this was because of being worried about the court case. He said that both his appetite and his concentration were fine. She said in interview:

> "There was absolutely no indication of anything psychotic at the time. He denied any hallucinations, visual or auditory, denied any thoughts of

having any special powers and he also denied any thoughts of being paranoid, that he thought anyone was against him or anybody was talking about him and he actually laughed in an appropriate way when we asked these questions so we just said 'if you feel that you need to speak to us again just ask the officers to contact us'".

51. She wrote at 4.33pm on 29 July in his case note history:

> "Seen by MHT [mental health team] at the request of Wing SO [senior officer], following an unprovoked attacked on fellow inmate. No evidence of psychosis or mood disorder. No history of mental health problems. No F/U [follow up] required."

52. The wing observation book shows that at 10.30pm, "The man requested listener but when told he would see duty listener then refused as he wanted to see his pal who is a listener for tobacco". In the early hours of the following day, 30 July, it is documented in his case history notes that "At about 02.15hrs, the man requested to see a listener, he said he will only see that listener, I explained to him that he is not on duty tonight that I will get the duty listener, he declined. Oscar 1 informed". (The Oscar 1 is the most senior discipline member of staff during the night.)

53. At the adjudication (discipline hearing) on the morning of 31 July, the man pleaded guilty to fighting with another prisoner. A written note of the adjudication reveals that he said that the other prisoner did not do anything and was not fighting him but just trying to get out his way. A report provided by the wing staff said "The man has not come to my attention while on Golf wing". He was found guilty and received seven days cellular confinement (CC - segregation from other prisoners) as punishment. He was placed in cell E1-14 in the segregation unit.

54. A nurse must complete a segregation safety algorithm to ensure that it is medically safe to segregate a prisoner within two hours of their arrival on the unit. A registered mental health nurse completed the segregation algorithm at 10.40am. The segregation journal (which has to be signed by every visitor to the unit) indicates that she came onto the unit at 10.40am and left at 10.42am. In interview she explained that the purpose of the algorithm is to find out whether the person has any current mental health issues rather than carrying out a full mental health assessment. The requirement is also for the algorithm to be completed after a discussion with the prisoner, reference to the clinical record and gathering information from other staff members. She said that her practice is to go back and check the medical records. However, an audit of the medical records (which indicates when the records have been opened) show that she did not so do in the case of the man. In interview, she said that most likely that she had forgotten to check. She could not remember him in any detail.

55. An officer wrote in the case history sheet at 5.36pm that day "The man was awarded 7 days CC on adjudication this morning. He has so far been polite and compliant to the regime. Received canteen and went on exercise this

afternoon. No issues raised." The officer was working as the desk officer that day (the officer assigned to completing all the documents rather than working on the wing) so did not have much contact with him. However, in interview she recalled that he had said to her that the other prisoners thought he was a sex offender and she had told him that nobody had access to his records and he seemed to accept that.

56. It is a requirement for all prisoners on the segregation unit to be visited by a member of healthcare staff every day, and by a doctor at least every three days. It was recorded that the man was seen by a member of healthcare staff and there were "no problems". The medical record shows that later that day he saw the doctor, who attends the unit every day, and was given ibuprofen (although it is not recorded why these were given and what medical complaint he had). Another requirement is that prisoners subject to cellular confinement are seen every half hour for the first 24 hours and every hour from then onwards (according to the National Security Framework). These visits are recorded on a sheet on a clipboard outside their cells.

57. At 9.23am, on 1 August, the man telephoned his father and spoke for ten minutes. He asked his father whether he had received a telephone call the night before. He explained that he had been "stitched up" and was down "the block". He said that he heard officers say that he was a "nonce, racist and police informer" and thought they had put things in his file. He said that they will be "getting him" when his father planned to visit him on 4 August. He asked his father to contact someone he knew who was related to a prisoner on the wing. He said that the officers told his friend that he was a "nonce" and that he cannot "get near him". He told his father that he could hear the officers showing people his file, although he also said that he could not hear anything through the windows because they were shut. (He had moved from G wing. The part of the segregation unit where he was located is in the basement under E wing. G wing is above E wing. During this period, there were only four or five other prisoners in the segregation unit.)

58. The man telephoned his father again at 9.51am and spoke for a further ten minutes. He told him that he had asked for a copy of his previous convictions and that he had punched the wrong person. He made reference to a previous probation report in which, he said, it was recorded that he had said that he was a racist because he had been bullied at school. On listening to the telephone call recording, the investigator judged that he sounded frightened throughout the telephone call and, at one point, whispered to his father, as if he did not want to be overheard.

59. On 1 August, an officer made the following entry in his case history notes at 3.20pm:

> "The man is wanting to tell myself and other officers that he is not in for a sex offence and has even gone so far as to take his legal papers on the yard to show other inmates. He keeps saying 'they're still talking about me'. "

60. At Pentonville, the duty governor goes to the segregation unit every day to carry out adjudications and speak to prisoners on the unit. (Once a week governors act as the duty governor and are responsible for the day to day running of the prison.) During the duty governor's round on 1 August, the man again asked for a printout of his previous convictions so that he could prove to other prisoners that he was not a sex offender. The duty governor advised him to ask wing staff for the printout the next day.

61. The Race Equality Officer recalled in interview that, on 2 August, she went to see the man at lunchtime. She said that she unlocked the cell and went and spoke privately with him in his cell. She did not sign the visitors' book although she explained to staff that she had come to see him. She explained that investigations into racial incidents are confidential and she would not disclose to staff the purpose, or outcome, of the interview. She said that as part of her investigation she interviewed Officer A, the man and the other prisoner involved. The other prisoner told her that the man had apologised to him and as far as he was the concerned the matter was finished with. She also showed the other prisoner the applications threatening the man and he said that he knew nothing about them.

62. In response to being asked by the Race Equality Officer about the punch, the man said it was a case of mistaken identity and that he had apologised to the prisoner concerned. He told her that people were calling him a racist and a rapist on G wing and that he had asked staff to check his prison file (known as C-Nomis) to see if there was anything like that written there. She said that she told him that she had seen his file and not seen anything about him being a rapist or racist. She did not show or tell him about the applications and he said nothing to her to suggest that he knew of their existence.

63. She said that she did not have any concerns about his presentation or state of mind. He was anxious to make a telephone call to his family and she passed this on to a SO who facilitated it whilst she was still on the unit. She explained to him that she did not think he should go back there if he thought people were calling him names. She said he agreed with her that he should not return to G wing.

64. After seeing him, she spoke with the population manager (responsible for allocating bed space within the prison) and asked it to be recorded that he should not return to G wing once he had completed his punishment in the segregation unit. This was recorded on his case note history on 5 August as 'a serious racial threat was made to him by inmates on G wing. In light of this he is not to be located on G wing'.

65. The prisoner was asked in interview if he had been aware of any ill feeling towards the man on the wing or any suggestion that he was viewed as a racist or rapist. He said that he had not heard any rumours or animosity towards the man.

66. Officer B was on duty and, at 5.00pm, she recorded that the man "continued to believe that others think he is a sex offender. Also thinks that staff have

given his PIN to other prisoners." (PIN is an individual number used by a prisoner to make telephone calls.) She had seen him on the previous Saturday, then been off duty the following day and returned to work on 2 August. She felt his behaviour was different from when she had seen him two days before and he had become very paranoid. She recorded "due to his behaviour, I have referred him to the [mental health team, or MHT]. The doctor also saw him on rounds and said she would contact MHT as well".

67. During her interview with the investigator, the officer said that the SO telephoned the referral through to the MHT after they had discussed the man. She then emailed the referral through. She wrote:

> "He has been located in the segregation unit since 31/07/10 and has displayed strange behaviour. He is very paranoid thinking that staff are giving out his pin number and that everyone thinks he is a sex offender. He is serving CC for an unprovoked assault on a prisoner who he thought was saying things about him".

The form asked 'How quickly must patient be seen? 24/72 hours'. However, she did not make any mark on the form. The medical records show this referral was made at 10.00am.

68. The CPN recalled taking the telephone call from the segregation unit and understood that staff were concerned about the man's behaviour. She said "that she felt that he was talking about like hearing voices and saying that he was a sex offender". The nurse said that she asked the officer whether she thought he needed to be seen now or if it could wait until after their multi-disciplinary meeting the following day. She was told it could wait until the next day.

69. The doctor carried out the healthcare round in the segregation unit that day. She said that her practice is to undertake this at the time the officers unlock each cell to give the prisoners their lunch. Before she saw the man, staff shared their concerns with her. Officer B remembered talking about her concerns with the doctor.

70. The doctor said in interview that when she spoke to the man the food trolley was there and the cell door was open. At the time, he was engaged in a conversation with staff who were trying to serve him food and was asking when they were going to bring his papers. She also said that he had a pen and paper and was "scribbling stuff down". According to the doctor, he did not acknowledge her at all in spite of her introducing herself. The officers then said that he could step back into his cell if he was not going to have any food. She completed her round with the officers. She shared Officer B's concern about him. Having been told that the officers had already submitted a mental health referral, she said she would follow this up by speaking to the mental health team. She said that she saw the staff return and give him a meal but that once the door was closed they heard the sound of him throwing the plate at the door.

71. When the doctor returned to healthcare she made notes on EMIS (computerised medical notes) from her notes that she had made as she had walked round the unit. She recalled in interview that she rang and spoke to the CPN. She said that the CPN said they were aware of the man and had his referral but that they had already seen him the Friday before. She said that she told her she thought he was becoming psychotic and they needed to review him again. The nurse agreed that they would discuss him at the mental health meeting the next day. During an interview with the investigator, the CPN did not remember speaking to the doctor.

72. The doctor wrote in the medical records at 1.14pm:

> "E1 rounds –very paranoid, pressured speech and verbally aggressive swearing. Unable to engage him. Notes already referred to MHT…..MHT informed about the patient. Stated he was seen last week with no evidence of psychosis but would discuss in MHT meeting mane (sic)".

In interview, the doctor was asked whether she was satisfied with this outcome. She said that she did not think he was going to kill himself and, as he was not locked up with anyone else, did not think he was in danger of harming others.

73. At 1.39pm, the man made a ten minute telephone call to his father. He told his father that the officers were giving out their addresses, including his grandmother's and asked his father to "be careful". He said that he could hear them at the door and that officers had told three prisoners to rape him in the shower. His father tried to reassure him and told him that he had spoken to someone with a relative in Pentonville who had said it was just a 'falling out' and he was blowing it out of proportion. He also said that staff were trying to make out that he was going mad and that he was going to be seen by the mental health team.

74. At 4.25pm, the man called his father again. He said he would see him on 4 August when his father was due to visit. He asked him whether he thought he should tell the governor when he saw him (presumably on the daily rounds) that he was being "stitched up". Again, he asked his father to be careful and said he was worried for him. He said that he would ring him the next day.

75. An officer made an entry in the man's case note history following the duty governor's rounds that day at 5.24pm. The officer recorded that he was concerned about making a telephone call because he had no credit. Officers were instructed by the duty governor to make sure he could use the PIN telephone.

Incident in the segregation unit

76. A SO was the Orderly Officer (operationally in charge of the prison during the night state) during the night of 2 and 3 August. An officer was working in the segregation unit that night. At 11.00pm, the SO wrote in the segregation observation book: "The man has a broken table leg with a screw sticking out of the top of it. He is covered in excrement and has made threats to 'bludgeon' anyone who enters his cell".

77. The report goes on:

> "The man made threats to bludgeon anyone who entered the cell and stated he would "bathe in their blood" after battering anyone who entered the cell."

78. According to the report, the man eventually calmed down and cleaned off the excrement after a lengthy conversation with the officer. Nevertheless, he was still upset and "continued to shout and make threats erratically until approx 3.30am". A further entry at 3.30am, on 3 August, was:

> "The man has washed the excrement off himself but still has in his possession a broom table leg with a screw sticking out of the top. He has been shouting for approx 3 hours on and off and has made specific threats to hit G-4 officers if they come near him".

The SO made the following entry at 4.50am:

> "The man has again covered himself in his own excrement and he is continuing to make threats against staff and continuing to threaten anyone who attempts to enter his cell. He is still in possession of a table leg type of weapon."

79. During interview, another officer said he came on duty that morning at 7.30am and, having seen the man, opened a dirty protest incident file at 7.45am on 3 August. He wrote that:

> "Whilst on duty in the segregation unit on 3/8/10 I observed this prisoner at approx 7.45hrs through the obs panel of cell E1-14. He had excrement smeared on his body and was holding 2 weapons. Stated that he would not be handing over weapons. Dirty protest log was started."

80. At 8.05am, a governor wrote in the dirty protest log:

> "I came down to have a chat with the man but he is not willing to talk to the DG [duty governor]. He had weapons on him and he threatens to assault staff. Staff will monitor his behaviour and planned intervention will take place this afternoon if the situation does not improve".

81. At 8.30am, the SO wrote:

> "I spoke to the man this morning and tried to work out what his issues are. He told me just wanted to be left alone he said he wanted a governor but

then declined to see the duty governor. He told me he had hepatitis and would assault any staff that tried to enter. He has asked for a print out of his core record and thinks that officers having been telling people he is a rapist. The decision has been made between the duty governor and myself to leave him at present and assess him regularly throughout the morning."

82. At 9.11am, the Independent Monitoring Board (IMB) was informed of the man's behaviour by the same officer. (The IMB routinely visit the segregation unit every day to speak with any prisoners about any concerns they might have.) At 9.20am, a member from the IMB wrote: "spoke and the man claimed to have finished his protest. He appeared calm and quiet and seemed willing to have a shower".

83. The Safer Custody Manager, and manager with responsibility for the segregation unit, was the duty governor on 3 August. He started duty at 9.00am and said he would have been made aware of the man's situation at the morning handover meeting. During an interview, he said he thought that the plan was to monitor the situation, try and find out what his issues were and get feedback during the day from segregation staff.

84. A nurse was the duty nurse on the segregation unit and recorded that she could not speak to the man during her round at 9.15am because he had weapons and was on a three man unlock (this means that at least three officers had to be present if his cell was unlocked). In her statement to the Coroner's officer, she said that that she telephoned the mental health team to report the change in his presentation. She said that she was told that he was being discussed at their MHT meeting that day.

85. At 9.30am, a governor wrote "Spoke with the man on Governor's rounds. He showed me two weapons which he agreed to give up after adjudications but has now refused to". The governor wrote that "staff noted that he had cleaned himself up and put on a new shirt but he was still on the protest".

86. The multidisciplinary mental health meeting took place at approximately 10.00 am where all mental health referrals were discussed. It was recorded in the man's medical record: "on seg, c/o paranoid ideation. Triaged by mental health team last week – no evidence of psychosis". Nevertheless, the team agreed that the prison's psychiatrist should assess him that week.

87. A psychiatrist, during an interview with the investigator, explained that she had been at that meeting but could not recall the exact events in terms of whether there was any urgency for the man to be seen that day. By this time, referrals to the MHT had been made by four people. The CPN told the investigator her recollection was it was agreed at the meeting that he would be seen that afternoon, not that week.

88. A mental health social worker, who had been on annual leave, attended the meeting that morning. She recalled that it was agreed that she and the

prison's psychiatrist would go and see the man that afternoon in response to the referrals and concerns about his behaviour.

89. At 10.30am, an officer wrote:

> "We went to see him to remove the weapons and give him the opportunity to use the shower. He refused to go to the shower and stated that we were trying to stitch him up and he wouldn't go to the shower because we would rape him. An officer explained that we cannot cease the dirty protest procedure until he had been in the shower. He continued to refuse to go to the shower and give us the weapons."

90. At 12.00pm, another officer wrote in the dirty protest log "Offered lunch – declined. Refused again to go into the shower and end dirty protest".

The planned intervention on 3 August

91. At 2.00pm that afternoon, the Safer Custody Manager authorised staff to carry out a planned intervention (where they would enter the cell to remove the man's weapons as he had failed to surrender them). He wanted him to have a mental health assessment at the same time as staff removed the weapons because he wanted to avoid another planned intervention, if possible. The CPN recalled taking a call from the Manager and told him that staff were on their way.

92. SO A was working as the orderly officer (overseeing the running of the prison) that day, assisted by another SO. Four officers were approached by SO A who asked for volunteers to take part in a control and restraint incident. (Staff are authorised, where necessary, to use control and restraint techniques which involve the use of reasonable force.) Two further officers also volunteered as did a further SO who was the senior control and restraint officer. They left the wing they were working on and went to the segregation unit where they were briefed by SO A. They were told that they needed to get into the man's cell, restrain him, clear the room of weapons and then let healthcare staff assess him. In all planned interventions, an officer has to video record the intervention. Staff are dressed in full control and restraint gear including a helmet and shield. After the intervention has taken place all staff have to complete use of force reports outlining their actions.

93. The man was ordered to surrender his weapons and go to the back of the cell. He did not do this or remove the barricade he had placed behind the door. The order was given to enter the cell. Initially, there was a delay as staff were unable to remove the door easily from it hinges and this took some time to be resolved. (These doors can be lifted from their hinges and opened inwards and outwards.)

94. Once in the cell, the man put up little resistance and dropped his weapons. No force was used on him. He was moved to the back of the cell by the officers holding up their shields. The three officers placed cuffs on him at the back of the cell. An officer spoke to him along with SO A and he was

compliant and responsive. One SO described him as being 'quite nervy and upset'.

95. At 2.35pm, the psychiatrist assessed the man while he was in his cell with the officers present in control and restraint gear. She was accompanied by the mental health social worker. In her subsequent medical entry, she recorded that he told her he had been hearing people shouting at him for two weeks, calling him "paedophile" and "nonce". He was concerned for his safety and wanted to use his paperwork to prove that he was not a sex offender. He told the psychiatrist that he had cut himself, "not to kill himself, but that nobody would grab him if there was blood on him". In his account of what others were saying, he said that he thought that his father had been killed. He assured the psychiatrist that he had not taken any drugs and would give nurses a urine sample but not officers. She noted that he had no history of mental health conditions or attempting suicide.

96. In conclusion, the psychiatrist wrote that the man had experienced an "acute psychotic episode, possibly drug related". She suggested that he be transferred to the healthcare centre for a full mental health assessment and that his urine be tested for the presence of drugs. She did not comment on whether an ACCT should have been opened or not. (Assessment, Care in Custody and Teamwork is the system used by prisons to identify, support and monitor prisoners at risk of self harm.) No ACCT was opened and there is no record of it being considered, despite his self harm. She summarised her findings in the incident report for the planned intervention and described his cuts to his arms as "superficial".

97. In terms of the cuts, the psychiatrist said that "he has made superficial grazes to his arms and he said that if there was blood on him the officers wouldn't actually physically touch him so it was to protect himself". The recording of the intervention confirms that she asked him about the cuts and he says that he is not going to do anything to himself. One of the control and restraint officers recalled him saying that he did not want to kill himself.

98. Later, the psychiatrist completed a F213 (report of injury to prisoner form which includes a drawing of the body for the doctor to signify where the injuries are) and identified

> "Superficial graze to right inner elbow and superficial laceration to left inner elbow. Cut himself today to protect himself 'as they won't grab me with blood'. Appears very paranoid. Does not wish to kill himself. On physical examination superficial graze right anteabital fossa. Superficial horizontal laceration below left anteabital fossa. No treatment needed for physical injuries."

99. The psychiatrist said in interview that, as it was a sudden acute episode, the man's behaviour may have been caused by a drug-induced psychosis because there was no known previous history of psychiatric illness. However, she noted that he denied the misuse of any drugs previously. She asked him if he would give a urine sample and remembered:

> "He was happy to do that but he said not to officers but he would to the nursing staff. He was very paranoid about officers, they wanted him to have a shower but he felt that he might be harmed if he had a shower."

She also said that he presented as calm when seen in the cell with the officers.

100. The mental health social worker said that the man said he had covered himself with excrement as he did not want anyone to touch him and people were saying he was a rapist and a racist. Her view was that he needed a period of assessment. She asked if he would give a urine sample to a nurse which he agreed to do despite previously saying he would not provide one for officers. She said that she thought he had superficial lacerations on his chest and that there appeared to be a small amount of blood mixed with his faeces.

101. She said she thought that someone, an officer, said something to her about opening an ACCT:

> "..they did say that to me and I said well the concerns are raised from yourself so you need to open the ACCT, not from us on the mental side, yes, so I did say that to them, yes."

Of all the other staff interviewed, nobody was able to recall any conversation about opening an ACCT.

102. One SO recalled that either the social worker or psychiatrist asked the man about the self-harm and that he said that he did it because he thought people would stay away from him if there was blood present. He said that he did not want to die. Following the intervention, the SO said there was a routine debrief and he said there was no mention of the cuts to him or a discussion about opening an ACCT. (The video recording cuts off during the discussion.)

103. The conditions in the cell were fairly cramped and hot. During her interview, the psychiatrist said that:

> "it was curtailed because basically the officers had all the riot gear on and were dripping, they were so hot and sweaty, but we felt as though we had made a thorough, although it was brief, a thorough assessment of his mental state that he was psychotic, that he needed to go to healthcare for monitoring and observation and that's the decision we made."

She recalled speaking with the Service Manager of Substance Misuse and Mental Health, who asked whether the man's admission was urgent and she explained that it was and that another patient would have to be moved to accommodate him.

104. The psychiatrist described her reasons for wanting to have the man on healthcare:

> "Well, it appeared as though he was psychotic so he needed trained staff to assess his mental state. We wanted to get a urine specimen off him and at some stage we may need to treat him with anti-psychotics or medication if that was necessary but he certainly needed monitoring of his mental state and it felt that it was much more appropriate there in healthcare with trained staff and also the environment of healthcare is more conducive than the segregation unit where lots of people are shouting and for somebody to be monitored and looked after".

105. The mental health social worker and psychiatrist then went back to the hatch to tell the man that they were worried about him and that they wanted him to come over to the hospital wing for a period of time. The social worker recalled that he said that he agreed but then said that they were "saying my dad is a paedophile, they're saying that I am a nonce" and that he looked quite scared. The psychiatrist recalled him saying that they were going to harm or kill his father and that someone had used his PIN to use the telephone.

106. The psychiatrist went up to healthcare and made a dictation straightaway which was put on the EMIS screen. The times recorded on the medical record are 4.51pm and 5.02pm. She said that she told the nurse who she believed would be the admitting nurse that he was very worried about his father and that it would be helpful if he could be contacted. Also, she explained that he was very psychotic and needed a urine sample and that this was a verbal handover. She knew the nurse but did not record her name. She also recalled that there were a few officers in the vicinity.

107. She said that the man would have come under the responsibility of one of two consultant psychiatrists. The following day, at approximately 10.00am, he would have been seen on the ward round, assessed and a management plan put in place. She understood that overnight he would be subject to 30 minute observations as a matter of course and any concerns would cause the observations of him to be increased. She said that, from her assessment, they were not worried about him harming himself, but were worried about his psychosis.

108. In interview, the psychiatrist was asked about whether there was any medication which the man could have been given to help to calm him down. She responded:

> "Well when we saw him he appeared calm during the interview. He didn't think he had any mental health problems and he was very psychotic so possibly if he had been offered them he may have refused but because one of the differentials was drug induced psychosis and I hadn't got a urine screen by then, I didn't feel that he would need any medication and he had also said to me that that he had slept well the night before so I didn't think that any night sedation was necessary but that would be the only thing I would have considered at that time … I didn't want to muddy the waters with any other medication and I thought that being in healthcare would be a calmer environment, that he'd have staff to talk to if he needed to because he was calm with me and I was able to talk with him so I

thought that would be sufficient for the 12-15 hours before he was seen in the ward round and that if at a later date he did need medication well there are GPs on duty or somebody on duty to be able to do that but at that time I didn't feel he needed any."

Arrangements to move the man to healthcare

109. The mental health social worker said that she made a telephone call to healthcare from the segregation unit asking them for a bed and the urgency with which it was needed. A nurse said in her interview with the Coroner's officer that she received a telephone call asking about the bed situation on healthcare as a bed was needed for the man. She went upstairs to confirm that a bed was available and advised them that an admission was coming from the segregation unit

110. The prison doctor said that she was informed at about 3.00pm that she would need to discharge one of the patients in healthcare to make room for the man. She said the Service Manager had told her this. The Service Manager thinks she spoke to another doctor about one of his patients who could be removed from healthcare to make way for the man. She said that she spoke to the psychiatrist and the social worker in the segregation unit directly to confirm that a bed was needed as it meant discharging the other patient. She said she told a nurse that someone needed to be moved at short notice. She also recruited an officer, who was just going off duty, to help move the other prisoner to make room for the man.

The man's move to healthcare

111. An officer, in interview, said that, given the man's previous erratic behaviour, he and another officer were asked to help an officer escort him to healthcare. By now, they had removed their control and restraint clothing. An officer said that he collected the man's property bag from the cupboard in the segregation unit. They approached the cell and an officer said that at first he was compliant but became aggressive as he wanted to get things out of the plastic bag which the other officer was carrying. Staff attempted to calm him down but he continued to swear and tried to grab his bag. He was given a final warning before being placed under restraint and placed on the floor. SO A arrived half way thought the incident and put cuffs on him whilst the other officers held his arms and head. An officer said that during this time, he dropped the bag containing his possessions and was unable to say who picked up the bag and took it to healthcare. He walked over to healthcare with the three officers and two SOs.

112. An incident file was completed giving the time of the restraint of the man as 4.40pm. SO A, the orderly officer, wrote that:

> "Whilst trying to escort prisoner the man from the seg to healthcare he became aggressive and agitated. He was restrained by the escorting staff. I arrived and placed the prisoner in cuffs. He was then walked in cuffs to healthcare."

(He indicated that he completed the form at 8.40pm.)

In the healthcare unit

113. In interview, an officer said that upon reaching healthcare there was a healthcare officer waiting outside the cell and the man was locked in the cell. He was unable to remember any detail and could not recall whether or not he had seen the plastic property bag. He presumed that SO A would have given a handover as he and the Control & Restraint Officer remained on the wing whilst the other three officers left. In relation to what happened at healthcare, an officer wrote "taken to healthcare and located in cell". Another officer wrote "escorted to healthcare and relocated in cell handover was given to healthcare staff".

114. Two prisoners were moved off healthcare to make room for the two new prisoners who came on. The man was placed on the west wing and a prisoner suffering from epilepsy moved onto the east wing. However, in the absence of a movement sheet it has not been possible to clarify the exact order or accuracy of events.

115. In terms of discipline staff, a senior officer on healthcare provided a written explanation of the staff complement that afternoon at the time when the man came onto the wing. According to this, there should have been three officers present while two officers had their tea breaks. According to the nursing rota, three staff out of nine were off sick, two nurses were working on the east wing and one on the west wing. Other duties for the nursing and discipline staff on the rota included running the outpatient clinic.

116. At around 5.00pm, an officer was in the centre part of healthcare when officers arrived with the man. He was aware that a prisoner was coming from the segregation unit and assumed this was him. The officer thought he was the only officer on the west side because other staff were dealing with the move of a prisoner. He said that he positioned himself outside cell nine, which had been cleaned and prepared, and the segregation officers took him into the cell. In interview, he said:

> "There was a little bit of talk because he was cuffed and they settled him down, which is normal, removed the cuffs and then they came out and I believe they closed the door behind them, that would be normal practice. Or I may have closed the door, I can't remember".

117. When asked about whether there was any verbal handover, the officer said:

> "Not really, no; not that I remember … You'd normally expect some sort of handover … They may have given me his name but they may have given me that or his prison number. But there was no real engagement; as far as I can remember there was no real engagement between me and those."

118. The officer said that he tried to speak with the man but he did not speak much back.

> "Just general talk really: 'how are feeling?' I've probably offered him some water, which is what I would normally do if somebody's been through something like that, would probably need a drink. But I'm guessing really what I said, I was just trying to talk to him, get some sort of conversation going but he wasn't forthcoming. He wasn't speaking back to me as far as I can remember. "

119. The officer explained that the normal process for a prisoner coming over to healthcare is for their possessions to be left outside the cell by either the prisoner or the escorting officers. Asked how officers from other wings would know this, he explained that "if I saw any possessions, if I saw a bag of property I would ask them to leave it outside". He said he did not see any bag of possessions nor was he handed any by the staff from the segregation unit. Someone placed the man's plastic bag of possessions in his cell although it has not been established who did this. The officer said "we would search through the possessions, make sure there was nothing in there that they couldn't have. Because we don't allow them to have lighters, we don't allow them to have razors in their cells".

120. The prisoner said in interview that he saw the man coming onto healthcare when food was being served. He said he was bare chested, with his hands cuffed behind him but was clean and he saw no signs of a dirty protest. The man said to him that he had been "stitched up".

121. In the EMIS record, there is an entry by a nurse. She did not enter a time but the audit showed that she wrote it at 5.13pm. She wrote

> "Admitted this pm from the segregation block patient has settled in well and had his supper. Seems preoccupied with his thoughts but has not displayed any overt psychotic symptoms. For assessment of his mental health state."

122. During an interview with the investigator, the nurse said that she became aware that the man was on the ward when she was finishing her shift at 5.30pm and walked around the whole ward as part of her final checks for the day and saw a new patient. She said that she had not been told that he had been bought onto the ward although she was aware that someone was coming from the segregation unit. She introduced herself to him, spoke briefly and then said she would see him the next day. She then went to see another nurse who was the most senior nurse available. She told her that her new patient was there and that she had made an entry and was now leaving.

123. Asked about what the psychiatrist had said in her interview about the handover she had given her, the nurse said that the psychiatrist had spoken to the team, not just her, and that she did not recall the handover in detail. She did not recall being told about the need to get a urine sample from the man. She said that she thought this was at about 4.00pm.

124. The nurse said that she expected the senior nurse to see the man as she was working on that side of the healthcare department. Asked what would be the purpose of the visit she said "basically to do an admission but I had already done an entry". Asked if that entry consisted as an admission she said:

> "No, there's like a care plan to be done but like normally we do a care plan but that's done in the first 72 hours, it's started the first 72 hours. It's part of the admission process that an entry has been made, the patient has arrived, and then we have like 72 hours to do the whole admission care plan and everything and so the night staff should have taken over from that, like it's basically 24 hour care so whoever comes over the next shift should take over the admissions process".

The investigator asked the nurse again what other parts of the admission process there are besides the care plan. She replied: "That's it. Yes, because when we left it was locked down so you couldn't actually go into the cell to assess the patient".

125. Although she was working a main shift (7.30am until 5.30pm) and mostly works on the east wing, the senior nurse said in interview that she was not told by the other nurse that the man was there. She said that at about that time she was helping other staff with the medication on the west wing. She also said that she had not been present for any discussions about him at all during that day and knew nothing about him until the next day. She said that, if she had been aware, she would have gone and introduced herself.

126. At 5.30pm, the officers working on main shifts finished and left one or two officers on evening duty. They would be relieved between 8.00pm-9.00pm (depending on what time the on coming night staff arrives) by one discipline officer who would be on night duty with a nurse. One officer finished his shift early at 4.30pm. He recalled that there was a mention of someone coming from the segregation unit.

127. Another officer completed the 30 minutes observations on east wing from 4.00pm-8.00pm. In interview, he said that although he was responsible for checking the 12 cells at those times, in between he might be somewhere else on the wing. He said that he did not see the man being brought onto the wing. He did not recall being present at any handover about him or having any meaningful interaction with him. He did recall that the other prisoner, the cleaner, came to him and said that the man wanted to make a telephone call. He said that the prisoner told him that he knew him and that he was "not himself". At the same time, a nurse came to give some information about another prisoner being brought to healthcare.

128. A nurse gave a statement to the Coroner's officer. She was on healthcare as she was dealing with another prisoner requiring admission. She said that she was approached by a "patient", who was the prisoner, and told him that she was not working on the inpatients' unit. He started to speak about the man and she repeated that she was not working on the wing and could not discuss

another patient with him. She then became aware that an officer was also present. The prisoner said that he knew the man and noticed he had lost weight. He also said the man had mentioned a telephone call.

129. The nurse said that the officer went to see the man and she continued to speak to the prisoner. She said that the officer returned and told the prisoner that the man had been polite and accepted what he had said. The nurse said she left healthcare shortly afterwards.

130. The officer said that he went to see the man in response to the conversation he had with the prisoner. He left the prisoner to speak with the nurse. He thought his conversation with the man took place at some time between 5.30pm and 5.45pm and this was the first time he spoke to him. In interview, he said that he said to the man:

> "I just said to him what did he want and he said I want to make a phone call. I said unfortunately I don't know you from anybody, you're come up from the segregation unit, you've just come up, and its patrol state and I wouldn't be able to let you out."

131. According to the officer, the man accepted this and then asked for a television and he explained to him that he would not be able to have one until he had been assessed for 24 hours. The officer said that none of the members of staff mentioned the man to him. He said that:

> "No, there was no handover. I mean until [the prisoner] told me his name and I went and put it in the book and then put it on the board, there's a white board with all beds and we mark who's in which bed, and then other than that that was how I got his name".

132. The officer said that he told another officer about the request for the telephone call and what he had done in response. The other officer was the other officer on evening duty. He had been detailed to the west wing in the afternoon. He said in interview that he became aware of the man when he returned from his tea break which was either at 5.30pm or 6.00pm. He said that he recalled seeing SO A there but none of the other staff who bought him over. He said that he took a telephone call in the office and they asked for the SO. He got him and heard the SO say that he had just "moved one over". He then had to move a patient off the west wing and left the wing so had no interactions with the man before the end of his shift.

133. The prisoner said that he passed some food to the man through the hatch in his cell. He spoke to him for about ten minutes, during which time he said that the man said that:

> "'They've stitched me up and they're hiding things in my bag, they're trying to get me nicked, they're putting kiddie porn in my bag' … in his bag so they could get him nicked and he said they're shipping him out to Littlehey prison which is a sex offenders' prison but I was saying to him they can't, it's not a remand prison, he said yes they're shipping me there tomorrow."

(The prisoner said that the man had spent two days in Littlehey on a previous sentence when he had been in the segregation unit at Blundeston and got moved to Wellingborough via Littlehey.)

134. After the prisoner had finished serving food, he went back and talked to him again and said he spent about an hour with him. He said that the man said:

> "The woman down the block she was going to let me in the shower, then I heard her saying to two other men go in there and rape him, I'm going to give you an hour or something, but don't worry its not rape because he's a paedophile', that's the things he was saying to me, and then he's saying to look that's the woman there talking, and I'm saying to him well there's no one there, there was no one … he started saying to me well you're on their side, you're sticking up for them, I know you're on their side."

135. The prisoner went to take a shower before he returned to talk to the man again. He said that he asked staff to let the man out for a telephone call as he wanted to ring his 'nan' because he said that he had heard people shouting from the wing that they had killed his father. However, the officer said he could not unlock him at that time. The prisoner said he thought his 'nan' was dead but did not know anything about his other grandmother, so he pretended to go and ring her using the man's PIN and came back and told him there was no answer. The PIN record shows this telephone call was made at 6.33pm. He told the prisoner that he would ring her the next day.

136. When it was time to leave the healthcare unit, between 7.00pm - 7.30pm, the prisoner went and said goodbye to the man and told him he would see him the next morning. He said he spoke to the nurse and officer and asked them to keep an eye on him as he was not his usual self. The officer said that another patient was admitted to the wing (whom the nurse had been speaking to him about earlier) and a patient discharged and that he had to prepare the cell for him. He said that the patient had required quite a lot of attention at the other end of the unit. He said that he gave another officer, the oncoming night officer, a verbal handover of the events but mostly about the other prisoner. In interview, this officer remembered being told that the man had come up from the segregation unit.

137. The 8.30pm and 9.00pm observations were carried out by the officer who also carried out the checks from 11.30pm until his last one at 3.00am. He said his usual practice at the start of his shift is to see if prisoners want their hatches kept closed or opened as it can be very disturbing if the hatch is opened and closed every time they are observed during the night. He remembered that the man's door hatch was left down. He recalled speaking with him and asking him why he had been in the segregation unit. He said to the investigator:

> "Yes, he was on the cell bell, I'd go down there, that wasn't a major problem, what's the matter, he asked for a TV, he asked for a television, and of course because I've got a night pouch I can't give him a television

anyway, I couldn't, it's not for me to give him a television." (At night, staff carry a pouch which contains a cell key and must only be opened in emergencies.)

138. He said that the man spent a lot of time at the hatch and that he would talk to him when he went past. He described him as "a little bit incoherent" and "worked up". However, he thought they spoke about football.

139. A mental health nurse was the healthcare professional on duty that night and had been working on the inpatient department for eight months. At the start of his shift at 8.45pm, there was a handover from day nursing staff and the night staff were told the man was there for a mental health assessment. The nurse said handovers usually involve both discipline and nursing staff. He did not recall anything in particular about him. He wrote one entry in EMIS at 9.27pm

> "The man was admitted to HCC late this afternoon around 17.30hrs for assessment. He is 27 years old with no previous history of mental illness. Has been observed to be acting strangely of late (covering himself with faeces and barricading cell). Assess by MHT and reported experiencing auditory hallucinations (people calling him paedophile) and persecutory delusions (believes others are trying to harm him and his father). The described symptoms have been going on for the last two weeks. Admitted Healthcare Inpatient Unit. Under care of psychiatrist. "

140. In interview with the investigator, the nurse said that the man was standing and shouting at his hatch a lot. He described the content of the shouting as. "mostly paranoid ideation". He said the man was loud for the first hour. The nurse said that he tried to reassure him but that at no point did he have concerns that he was at risk to himself.

141. At 6.10am, on 4 August, he wrote:

> "Nocte: Intermittently noisy and disruptive. Shouted through hatch. Speech evolved about him being stitched up and others calling him names. Has requested and was given paracetamol for toothache and advised to see doctor for prescription if pain persists. He went sleep around 3.30hrs and remains asleep."

142. There was a verbal handover at 7.45am. Another nurse was at this meeting and remembered that the mental health nurse said that the man was quite disturbed during the course of the night. Officer A came on duty the next morning and recalled the handover and that the mental health nurse said he had been banging and shouting. Officer B was also on duty on the east wing. He remembered that the man was vocal that morning and shouting out that people were killing his dad.

143. At 7.30am the observation log was signed by another officer who took over from the night officer. Officer A signed at 8.00am for the first time. He said that when he started the observations the man's hatch was up but he does not recall anything else about this first observation. (It is not known when or

why the hatch was placed up. The night officer had said it was down during his checks.) Officer A said that one of his duties for the morning was to ring visits to see if any healthcare prisoners had visits that morning. He thought this was some time after 8.20am. He was told that one prisoner had a visit and Officer A said that he and Officer B got this prisoner out for a shower. This was not the man (although his father was booked to visit him that day).

144. Officer B signed for both the 8.30am and 9.00am observations. He said that during the morning the man shouted out for a while and was then quiet before he shouted out again. He also recalled that he banged on the window at times. He thought that, at the 8.30am observation, he was sat on the bed and asked if he was ok. The officer said he ignored staff. At some point between 9.00am -9.30am, he took the other prisoner to the visits hall. In interview, he recalled:

> "I remember at one point, I think when I was checking him at 9 o'clock he was standing there sort of by the window with his hands up. He wasn't banging then, but screaming 'they're killing my dad, they're killing my dad'. But he was kind of lucid but not kind of lucid. There were also other comments coming out, I can't remember the exact, but it's not what you'd expect, he obviously seemed quite unwell from the sound of it."

145. The prison Quaker chaplain was interviewed by both the Coroner's officer and my investigator. In his statement to the Coroner's officer, he said he walked along the corridor just after 9.00am with officers when the man called out and asked who it was. He said the officer replied that "it's the chaplain" and he then asked to speak to him. The chaplain said that his normal practice was to go into the cell but the officers advised him not to as they felt it was unsafe as he may be violent.

146. The chaplain said that he was told that the man had a weapon the day before and had undertaken a dirty protest. The chaplain did not open the observation hatch. He said that the man said that his father had been shot in another prison and that he wanted to know what was going on. He asked how he knew this but he was unable to remember what he said in response. He said that he also said that "the officers were trying to hurt him". The chaplain told him that he was sure that they were not. He said the man was very agitated at this stage. He asked the chaplain to pray for him which he agreed to do. He then left healthcare.

147. In the chaplain log, the chaplain wrote

> "Note written after I heard of his suicide attempt this morning – spoke to him through the door, at officer's request. He said he would be dead by tomorrow and that 'they were trying to kill me' – I spoke to the officers. We thought he was paranoid or speaking for effect. He did not say he was going to commit suicide or make threats."

148. Officer A could not recall any details of the conversation with the chaplain. He said that about 9.30am he went to check again. He said the man had gone quiet. He was in cell 9 which was opposite the office and slightly to the right.

149. When he looked through the hatch he could see the man's legs and realised that he was not moving. He shouted out and then opened the cell. At this point, he saw that he had a plastic bag over his head. He put him on his back and tore the bag open. He noticed that he had a belt attached tightly around his neck, which the officer removed. He could see that he was not breathing and immediately performed some rescue breaths after he put on his face mask. He blew his whistle at 9.31am. A Level 1 call (indicating that a life threatening situation was taking place) was put out over the radio and staff and nurses started to arrive. He said that another officer took over the breaths.

150. A trauma nurse arrived on the scene three minutes after the alarm went out. She saw that CPR (cardio pulmonary resuscitation) was being carried out by staff, although without equipment. The man had no pulse. Another nurse brought the resuscitation trolley from the treatment room and handed equipment to her colleagues when requested. Two more nurses assisted with CPR. The trolley arrived and the trauma nurse inserted a Guedal airway (airway device used to maintain an open airway). Then an ambu bag (a self-reinflating bag to assist ventilation – can self-reinflate with room air or from oxygen source) was used to apply oxygen. Two prison doctors, including the lead doctor, arrived. The ambulance log shows that the call was made at 9.36am and it arrived at the prison at 9.45am. The paramedics were at the man's side at 9.50am and Adrenaline was given. At 10.11am he was moved to the ambulance and at 10.21am discharged to hospital with paramedics still working on him.

151. The man's father had registered at the visits centre at 9.13am. It was during the attempt to resuscitate the man that healthcare received the telephone call from the visits hall to say that he was there to see his son. He was spoken to by staff and a family liaison officer travelled with him to hospital. Later that morning, a governor and the Head of Healthcare spoke with the family at the hospital.

152. The man did not regain consciousness and a few days later, at 7.00pm, the life support monitor was switched off. He was pronounced dead at 7.20pm. His family were with him at the time. The prison FLO continued contact with the man's uncle having been asked to do so by his grandmother, who was his named next of kin. The prison offered financial assistance towards the funeral expenses.

ISSUES

Clinical review

153. The local Primary Care Trust conducted a clinical review into the care the man received whilst at Pentonville. A clinical reviewer carried this out on their behalf. She made three recommendations, all of which are included below.

ACCT monitoring

154. Whilst in the segregation unit, the man cut his arms. He told staff he did this so that they would not touch him but he was not going to kill himself. The injuries were described as "superficial" by the psychiatrist on the medical form. When he spoke about them during the planned intervention there were at least eight people in the vicinity at the time including the Head of Safer Custody.

155. The requirements set out in Prison Service Order 2700 (Suicide prevention and self-harm management) are clear:

> "All acts of self-harm or statements of intent to self-harm must always be taken seriously no matter what the perceived reason for the self-harm is. Attitudes that see some people who self-harm as "genuine" and others as "manipulative" are dangerous and should not be tolerated by managers. Where the self-harm is goal-oriented, the prisoner should be helped to find a more constructive way to meet their underlying need.
>
> **13.2 Follow-up actions and care for prisoners who have self-harmed**
>
> *In the event of any incident of self-harm staff must (where there is not one open already) open an ACCT Plan. This must be done no matter what the reason for the self-harm*. (If an instruction is italicised then it is mandatory.) Opening an ACCT means that the individual will be interviewed by an ACCT Assessor who will talk with them about what led up to the incident, what they were trying to achieve and why and how they think further self-harm could be avoided or reduced in the future. The care plan for someone whose self-harm was not suicidal in intent will be different from one who is determinedly suicidal, but they still require care."

156. All officers and governors interviewed were asked whether they were aware of the PSO guidance. Without exception, all knew the detail of the PSO and what it said about any act of self-harm. The locum psychiatrist was working her second day at Pentonville. She had experience of working in secure units but had not had any formal training about working in prisons and prison protocols, including the ACCT process. She was not aware of the Prison Service Order 2700 which stipulates that any act of self-harm must result in the opening of an ACCT. (This will be considered later in the report.) The social worker conducting the assessment with the psychiatrist said that

someone said something to her about opening an ACCT. No other staff interviewed could recall this conversation.

157. The man self-harmed, therefore an ACCT should have been opened. Being subject to ACCT monitoring may not, in itself, have saved the man's life. However, the ACCT process involves assessment and consideration regarding an individual's suicidalilty. The fact that he had self-harmed meant an ACCT should have been opened regardless of how staff perceived his intentions. The failure to do so was a clear breach of policy.

158. The duty manager and Head of Safer Custody was the most senior person present and was asked in interview when he became aware that the man had self-harmed. He said that he did not know if he knew at the time of the planned intervention or after he had been relocated to healthcare. He said he could not hear the conversation that the psychiatrist was having with the man because he had stood back from the main group of staff in the cell to avoid it being more cramped in there. He did not recall any conversation about opening an ACCT.

159. On reflection, in interview, he said

> "The only thing I would say about had an ACCT been opened on the man he was on half hourly observations anyway. In healthcare ….an ACCT could have been opened and in hindsight when you look at the PSO it probably should have been opened but observations on him would not have been any more than half hourly observations."

160. Routine observations in healthcare are not a legitimate alternative for supporting someone on an ACCT. Observations are only part of an ACCT support plan. These, and the care map and case reviews, provide substantive examples of the more holistic care ACCT procedures offer compared to the half hourly routine checks in healthcare.

161. Only after assessment and discussion would the level of observations of an individual on an ACCT be decided. Therefore, the Head of Safer Custody was incorrect to assume, that half hourly observations would have been the outcome. To focus solely on the level of observations also ignores the other supportive aspects of the ACCT.

162. The investigator spoke with the Governor following her interview with the Head of Safer Custody and was told that he would be spoken with about his comments. We trust that this has been done and the Governor has reassured himself that all staff do not believe that there is an effective alternative to ACCT procedures when safeguarding those at risk of self-harm.

The Governor of HMP Pentonville should remind all staff that an ACCT must be opened following every episode of self-harm, in line with the requirements of PSO 2700.

163. In response to the above, the Governor provided the following statement:

"The Head of Safer Custody disagrees with the PPO's interpretation of events that occurred at the time.

Since the interview he has had time to reflect on the events and is sure that whilst the man was in the Segregation unit, he was unaware that he had cut himself. Had he been aware that he had cut himself he would have opened an ACCT.

He believes that he was made aware that the man had cut himself the following morning after his suicide attempt when a number of people including, himself, were together in Healthcare discussing the event."

ACCT training

164. During the course of the investigation, it came to light that two of the nurses working on the healthcare unit were not ACCT trained at the time of the man being on the unit. The expectation is that all staff who come into contact with prisoners are trained in the ACCT process.

165. The psychiatrist had not been briefed about ACCT. She was on her second day working as a locum and had not been inducted in prison protocols. She should have been trained as a member of staff in contact with prisoners.

The Governor should ensure that all staff have undergone ACCT training.

What happened to the man's possessions?

166. There are two questions in relation to the man's possessions which he was able to use to apparently take his own life:

1. Why did he have his possessions in the cell with him?
2. If they had been searched in line with policy, what would he have been allowed to have with him?

Pentonville's Inpatient Care and Admission Policy (2003) states

"All new admissions will be searched on their arrival and all unauthorised articles will be removed"

167. The clinical reviewer reports:

"The man was transferred into the Healthcare Wing and was left in possession of all of his property including a plastic bag and a belt. The policy to search a prisoner was not clearly understood by staff and there was no clear guidance offered to guide staff in understanding how to link the risk assessment with the removal of specific property items."

168. It is worrying that no member of the healthcare staff was able to explain how the man's possessions got into his cell, despite the requirements of Pentonville's healthcare admission policy.

169. If the man had been subject to ACCT procedures, there would have been a requirement for staff to consider items he could have in his cell. However, it is discouraged to routinely remove possessions. PSO 2700 (Suicide prevention and self-harm management) states:

> "However, removing personal belongings from a person who is feeling hopeless and depressed … can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so."

170. As previously discussed, the man was not on an ACCT. Nevertheless, healthcare has its own policy about searching prisoners. The clinical reviewer makes the following recommendation, which we endorse:

The Head of Healthcare should ensure that all staff are aware of the need to undertake thorough risk assessments about which property, if any, should be removed from prisoners. There should be clear documentation that demonstrates and supports this decision making.

The segregation safety algorithm

171. The man was in segregation as a punishment for his behaviour. Time spent in segregation is recognised as being stressful to prisoners. One of several safeguards to protect the prisoner's welfare is the segregation health screen.

172. The segregation health screen has guidance contained within the form. This states that the purpose of the health screen is to determine whether there are reasons against holding a prisoner in segregation. It is a "snapshot" of the prisoner's mental well being. It is not intended to be a comprehensive mental health assessment; neither should it take the place of one.

173. The form also provides instruction to the clinician undertaking the health screen which includes:

> "Nurses must complete the algorithm after:
> - A discussion with the prisoner
> - Reference to his clinical record and any other relevant documentation e.g. incident report
> - Gathering information from other members of the care team/discipline staff

174. It states in bold at the bottom of the form that the clinician is "advised to make an appropriate clinical record".

175. The nurse said that she did not check the man's records prior to the completion of the algorithm and, in interview, said she most likely forgot to do so. The segregation visits log shows that the nurse was on the unit for only two minutes.

176. The segregation algorithm was completed seven days prior to the man's death, and there were other opportunities to assess him in the meantime. Nevertheless, it is a matter of concern that the segregation health screen was not completed following a review of the previous notes and in such a short period of time.

The Governor and Head of Healthcare should ensure that all medical staff are aware of their responsibilities in relation to the segregation safety algorithm.

Lack of communication between segregation staff and healthcare

177. The man was moved from the segregation unit to the healthcare centre as staff were changing shifts. Staff in the healthcare unit had been told that a prisoner was coming over from the segregation unit on the afternoon of 3 August. The investigator was told that a prisoner had to be moved off west wing to accommodate him. Another prisoner was also transferred onto the east wing of healthcare at some point that day. He was taken to the healthcare unit at the end of the core day. Staff working a core shift were leaving the establishment and handing over to those working in the evening. The regime was going into patrol state. The decision to admit him to healthcare was made at 2.30pm and he was eventually moved at 4.40pm.

178. The delay admitting the man to healthcare was understandable. The balance of his safety and the security of the prison meant that such an intervention could not be spontaneous and needed careful planning. However, the investigation could not establish whether the delay in finding a bed and discharging prisoners off the healthcare centre contributed to the delay. There was no record about the admission or discharge of prisoners to the healthcare centre. Many staff were involved in the arrangements for his move, but apparently none could remember the circumstances of his admission on 3 August. Regardless of the timing of his move, staff should have ensured an effective hand over, with a clear explanation of the reasons for his admission to healthcare. The admission should have been clearly recorded.

179. When the man was brought over from the segregation unit and force was used, a F213 form should have been completed to register any injuries a prisoner may have sustained in the use of force. This is initially completed by the staff member noting the injuries (or absence of any) and then the medical staff who gave treatment. SO A, the orderly officer, ticked the box on the use of force document which stated that a form F213 was completed. The investigator requested a copy of the F213, but at the time of issuing the draft report, no such document has been provided.

180. According to guidance given on the form, a F213 must be completed and attached to the incident report even if the prisoner does not appear to have any injuries. All documentation relating to a prisoner who has died in custody must be provided to the Ombudsman's investigator. It is a matter of concern that the F213 was not provided.

181. If a form had been completed by a healthcare professional when the man arrived at the healthcare unit, it could have provided another opportunity for the self-harm injuries to have been assessed and acted upon. It is regrettable that the SO could not be interviewed as part of this investigation and the F213 form has not been found.

The Governor should ensure that an F213 is completed and retained every time force is used.

Request for a urine sample

182. The clinical reviewer comments that after the psychiatrist saw the man "medication was not prescribed at this point as, in line with good practice, a urine drug screen was requested." Although she wrote extensive notes in the medical records and she said, in interview, that she told a nurse that he needed a test, no urine test was carried out. The nurse said she did not remember being asked to do so.

183. In the clinical review, the clinical reviewer goes on to write:

> "Had the urine test requested for the man been carried out urgently using a rapid analysis test such as a 'dip stick', then whether or not he had taken any illicit drugs could have been established and appropriate prescribing could have been put in place to offer him some sedation if it was safe to do so. This may have had an effect on his ability to rest and sleep on the night before he took his life and may have calmed his aroused state."

The clinical reviewer recommends the appropriate availability of equipment for urine tests, which we endorse.

184. We also make the following recommendation

The Head of Healthcare should ensure effective and appropriately documented communication between members of the healthcare team, so that there is an auditable log of the treatment requirements of patients.

Not sharing information about the threats in the applications

185. When he was on the induction wing, the man hit another prisoner and said he was not a racist. Due to the accusation of racism made against him, the altercation was investigated as a racial incident. A race relations investigation is a confidential process and the investigation officer only reports their findings to the Governor of the establishment. Had the incident only involved the fight then this may have been understandable. However, the applications which were found on the wing the same day suggested that there was a tangible threat to him from another prisoner.

186. We would expect this to have been shared with the staff on the segregation wing so they could consider the man's behaviour in light of this information. He did believe he was at risk from others, but staff told the investigator that they thought he was paranoid. Whilst there is nothing to suggest he was aware of these applications, it may be that something had taken place on the wing which played a part in his fears.

187. The psychiatrist was asked in interview whether knowing about these applications would have changed her assessment of him as being paranoid and suffering from a psychotic episode. She did not think it would have done. Notwithstanding this, it was an important piece of information which should have been shared with staff on the segregation unit.

188. It is difficult to see how sharing this would have compromised the confidential nature of the racial incident investigation. The applications might have been an indication that the man was not paranoid about being threatened. At the very least a security report should have been submitted after these applications had been discovered. Staff on the unit where the potentially at risk prisoner was located should have been told. Also, staff should know that they may have prisoners on the wing threatening other prisoners. On 5 August, an entry was put on his PNOMIS records to say that he should not be returned to the wing because of a serious threat. This was five days after the applications had been found.

The Governor should remind staff investigating racial incidents about the need to share information when prisoners may be at risk from others.

Healthcare internal report into the death of the man

189. In the week after the man's death, the local PCT (in their provider role) commissioned a quick review of the clinical care that he had received while he was at Pentonville. A copy of the draft and final report was given to the investigator to aid our investigation.

190. We understand that the review was carried out quickly but, in our view, it failed to establish an accurate sequence of events. A number of details seem to have been accepted on face value. (For example, one officer was not interviewed and it was only through our investigation that he was identified as

the healthcare officer involved in locating the man onto the unit, some months after his death.) This resulted in misleading conclusions about the quality of clinical care experienced by him at Pentonville.

191. The internal investigation prematurely reassured healthcare staff that they had acted according to policy, and therefore made it difficult for the investigator to establish a true record of events. We suggest, as we have commented in a previous investigation report, that the Head of Healthcare should be explicit about the purpose of the exercise so that a sufficiently robust account of events is established and acted upon swiftly if necessary. As this is the second time we have brought this to the Head of Healthcare's attention, we make the following recommendation:

The Governor and Head of Healthcare should ensure that the aim of the internal investigation is clear and staff are reminded that the conclusions may be subject to change following the Ombudsman's investigation.

Lack of recording information in healthcare

192. Some staff in healthcare did not know how to use PNOMIS (the software system used to record all information about prisoners which replaced much of the paper documentation). The officer who placed the man into his cell on healthcare said that he could not use PNOMIS as there was a problem with his password. He also said that the arrival of a new prisoner onto the wing would not necessarily prompt an entry in the observation book. The investigator drew this to the attention of the Governor at the time and was told that this would be addressed immediately.

193. The investigator asked for various documents from healthcare, such as admissions and discharges from the unit, but these could not be provided. It was also not possible to view CCTV as this was not working and had not been for a significant period of time.

The Governor and Head of Healthcare should ensure that all staff in healthcare, both medical and discipline, are aware of the importance of all records, including documents, CCTV and PNOMIS.

Telephone call

194. One of the man's requests was to make a telephone call. The psychiatrist had verbally passed this message on, although it remains unclear as to exactly how many people she told. An officer was approached by a prisoner to request a telephone call on the man's behalf, and asked directly by the man. Unfortunately, the prison was in patrol state when the officer was on duty and he said that it was not possible to unlock him to make the call because of the strict security requirements at that time. However, other officers on the unit suggested to the investigator that a telephone call could have been facilitated despite the patrol state by getting permission from the duty governor to use the telephone and calling the man's father himself.

195. The officer acted within the strict security requirements demanded by patrol state. He had not realised the extent of the man's anxiety and it is only with hindsight that the possible importance of such a call can be realised.

Visit

196. The man's father was waiting in the visits hall when he was discovered in his cell on the morning of 4 August. When a prisoner's visitor arrives, the visits centre calls the wing where the prisoner is located so that arrangements can be made to escort the prisoner to their visit. Given that the man was moved from the segregation unit to healthcare after 4.30pm, it might have been that any notification that his father was in the visits hall for a visit went to the segregation unit rather than healthcare. Internal telephone calls are not recorded so the investigation could not establish who was contacted regarding the visitor.

197. The investigator listened to a recording of the telephone calls the man made to his father. His father mentioned the forthcoming visit so he would have been aware that it was planned for that morning. He had expressed his anxiety to his father about the visit, which he later repeated to a prisoner. He feared for his father's safety during the visit. In one of the calls to his father, he said "something will happen in the visits hall". If the message had come through to healthcare to say that his father was in the visits hall, he may have been taken over there earlier that morning.

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CONCLUSION

198. Having been assessed as not suffering from any mental health illness by two CPNs on 29 July, the man's mental health deteriorated once he was placed in the segregation unit on 31 July. He spoke of being at risk from attack from other prisoners and given the two applications found, there may have been some genuine risk. It is not known what he knew, if anything, of these applications. His anxiety and fear raised whilst in the segregation unit to the point where he barricaded himself in his cell and made weapons to protect himself. He also cut himself to stop staff touching him. No ACCT was opened, against the mandatory requirements of the Prison Service Order.

199. After assessment by a psychiatrist, the man was moved to the healthcare centre. There was not an effective handover to healthcare staff. Furthermore, the healthcare policy regarding property in cell was not adhered to, and he had access to his possessions in his cell, including the bag in which they were contained.

200. Staff interviewed did not seem concerned about the man that evening although his friend and fellow prisoner was alarmed by his behaviour and told staff. No meaningful action was taken or concerns raised. Overnight, he was seen alternatively by a discipline member of staff and a nurse but, again, they did not seem unduly concerned. In the morning, he expressed significant distress and fear about his father being in danger. He was due to be assessed within an hour of this by two psychiatrists although he would not have known this. He apparently took his life before this could happen.

201. It is not known if anything could have changed the outcome, but the investigation has found that the man's anxiety and distress were not recognised in the sixteen hours he was in the healthcare centre. The circumstances of his death reinforce the importance of sharing information across the multidisciplinary team involved in his care.

RECOMMENDATIONS

1. The Governor of HMP Pentonville should remind all staff that an ACCT must be opened following every episode of self-harm, in line with the requirements of PSO 2700.

   Accepted. All staff to be reminded of correct procedures for ACCTs being opened in Staff Information Notice.

2. The Governor should ensure that all staff have undergone ACCT training.

   Accepted. All new staff to receive ACCT training as part of induction programme. Training managers will contact Safer Custody manager to advise ongoing refresher training about ACCTs bi-annually, with regular reminders through staff meetings, briefings. Any staff not following procedures will be raised to the attention of the Safer Custody lead.

3. The Head of Healthcare should ensure that all staff are aware of the need to undertake thorough risk assessments about which property, if any, should be removed from prisoners. There should be clear documentation that demonstrates and supports this decision making.

   Accepted. An Operational Policy has been completed and approved by the Pentonville's Clinical Governance Committee. In the policy a clear handover section outlines what process must take place and this includes a risk assessment of all property. The policy clearly outlines accountability and responsibility for ensuring the process is completed in all cases.

4. The Governor and Head of Healthcare should ensure that all medical staff are aware of their responsibilities in relation to the segregation safety algorithm.

   Accepted. All healthcare staff have been reminded by the Head of Healthcare of their obligation to record accurately in the patient's clinical records at the time of review. Subsequent training sessions have been made available to staff at regular intervals to support staff to improve their performance in this area. A System One terminal has been installed in the segregation unit to ensure access to the full clinical records for staff carrying out patient's assessments.

5. The Governor should ensure that an F213 is completed and retained every time force is used.

   Accepted. Duty Managers to conduct daily checks of a Use of Force paperwork submitted to ensure F213s are attached as a matter of course to Use of Force paperwork.

6. The clinical reviewer recommends the appropriate availability of equipment for urine tests, which we endorse.

Equipment is available at all times in the unit and regular checks are now carried out to ensure safety of equipment and stocks.

7. The Head of Healthcare should ensure effective and appropriately documented communication between members of the healthcare team, so that there is an auditable log of the treatment requirements of patients.

   Accepted. The inpatients admissions template was reviewed as part of the Operational Policy to reflect this need. From July 2011 we began to operate with System One (electronic medical records); this will be reviewed to ensure an appropriate process is in place for medical requests (for urine, bloods, etc) and that they are properly actioned. The process will be auditable with clear ownership and accountability lines for all staff.

8. The Governor should remind staff investigating racial incidents about the need to share information when prisoners may be at risk from others.

   Accepted. The Race Equality Officer to devise a quality management check in order to check that any information about risk is disseminated appropriately.

9. The Governor and Head of Healthcare should ensure that the aim of the internal investigation is clear and staff are reminded that the conclusions may be subject to change following the Ombudsman's investigation.

   Accepted. The investigation process has been fundamentally re-designed since August 2010. We now have a clear 7 and 28 day review mechanism in place which includes governance from NHS Trusts and the Prison.

10. The Governor and Head of Healthcare should ensure that all staff in healthcare, both medical and discipline, are aware of the importance of all records, including documents, CCTV and PNOMIS.

    Accepted. All healthcare staff have been reminded by the Head of Healthcare of their obligation to record accurately in the patient's clinical records at the time of review. Training sessions have been made available to all staff that work in healthcare, to ensure they are aware of the importance of all records, including documents, CCTV and PNOMIS. This training will be delivered on an annual basis, and additionally on a needs basis for all staff.