Investigation into the death of a man at University College Hospital, whilst in the custody of HMP Pentonville in September 2010

Report by the Prisons and Probation Ombudsman for England and Wales

April 2011

This is the report of an investigation into the death of the man in September 2010 at University College Hospital, London, whilst in the custody of HMP Pentonville. The man's cell mate had discovered him hanging from the window bars. Prison staff attempted to resuscitate him before he was taken to hospital by emergency ambulance. However, despite the efforts of medical staff, he was pronounced dead at 9.52am. He was 35 years old and had been in prison for less than 24 hours.

I offer my sincere condolences to his family and everyone touched by his death.

One of my investigators conducted the investigation on my behalf. A review of the man's medical care was commissioned by NHS Islington. I am grateful to the clinical reviewer for his report and contribution to this investigation. I would also like to thank the governor of Pentonville and his staff for their cooperation. I am particularly grateful to the member of staff who provided a high level of prison liaison and ensured that the documentation was in good order.

The man was sentenced to 12 weeks in custody and arrived at HMP Pentonville on 9 September 2010, from Waltham Magistrates Court. Nursing staff assessed him and considered that he needed substance misuse treatment from alcohol and drugs, so he was taken to a cell on the IDTS wing. No regular observations on him were made by staff during the night and he raised no concerns.

At around 8.15am the following morning, the man's cell mate alerted staff by pressing the cell call button. The officer who responded looked into the cell through the observation panel and saw the man hanging from the window bars. Staff entered the cell, released the ligature and performed cardio pulmonary resuscitation (CPR). They were assisted by nursing staff and efforts to revive the man continued until the arrival of paramedics. The paramedics continued CPR before taking the man to University College Hospital, London.

My investigation highlights inadequacies in the procedures for assessing, treating and observing prisoners under going substance misuse treatment. I make four recommendations on these matters, as well as a recommendation regarding the identification of cells where prisoners might require additional monitoring. I am also concerned about the apparent length of time that had passed between the man taking his life and being discovered. In spite of statements and interviews with staff who conducted the early morning checks, I am unable to clarify how long the man had been hanging before he was discovered. However, the clinical reviewer has researched this area and provides some helpful information within his review. The governor was alerted to these findings and concerns regarding the quality of roll checks during the course of the investigation and I am satisfied that he is taking appropriate steps in respect of the discrepancies identified.

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

Jane Webb
Acting Prisons and Probation Ombudsman **April 2011**

CONTENTS

SUMMARY

The man was a Georgian National who had been living in the United Kingdom since November 2003. He was arrested on 8 September 2010, for theft and sentenced the following day to 12 weeks in prison. He had been in Pentonville once before. He was 35 years old.

When the man arrived at HMP Pentonville on 9 September, he was assessed on the first night centre and his level of English was considered as adequate for him to be able to understand what he was being asked and to communicate his needs. He was assessed and reviewed by three healthcare professionals, including a healthcare assistant, substance misuse nurse and a general practitioner (GP). The health assessments identified him as needing substance misuse treatment, treatment for both alcohol and illicit drugs. However, the investigation has found that the way in which these assessments were conducted and the information was shared between the healthcare staff could be improved.

Following his healthcare assessment and first night in custody procedures, he was taken to F wing, which is the drug treatment wing at Pentonville. The investigator was told that it was normal practice for prisoners coming on to the unit to be initially allocated to either F5 or F4 landing so that they would be observed more regularly. However, due to limited spaces, the man was given a cell on F3. The presence of new prisoners on F3 landing was not communicated to the night officer, and there is no evidence of any checks being made of the man during the night. This contravenes the prison's policy which requires the night nurse to conduct regular checks. The nurse on duty on the night of 9/10 September said that she was not told of these requirements and had not been given a full induction before starting work on F wing. My report makes recommendations on these issues.

Between 5.00am and 5.30am, the officer who had been on night duty, conducted a full roll check of the 118 prisoners on F wing. During her check, she was required to account for every prisoner, but she could not recall seeing the man particularly, or anything unusual about his cell. At 6.45am, the early unlock officer who took over from the night duty officer arrived for his shift to replace the night duty officer and, before doing so, was also required to conduct a full roll check of F wing. The officer's roll check was said to have been completed between 6.45am and 6.55am and he could not recall seeing the man or anything unusual about his cell. The paperwork for the roll was signed by the officer at 7.05am.

At 8.15am, the first officer on the scene who was working on F3 landing along with the second officer on the scene was alerted to a cell call bell. The first officer on the scene went to the cell and on looking through the observation panel, saw the man hanging at the back of the cell from the window bars. The officer immediately opened the cell door and called to the second officer on the scene for assistance. The first officer on the scene supported the man and, with the help of the second officer on the scene he cut the ligature from the window and they placed the man on the floor.

Another officer, who had heard the first officer's call, radioed for medical assistance. The first officer on the scene administered cardio pulmonary resuscitation (CPR) to the man and was quickly assisted by the first nurse on the scene and second nurse on the scene, followed the substance misuse manager, who had been contacted by the second nurse on the scene, the substance misuse manager assessed the man but could not find a pulse and CPR continued.

The substance misuse manager attempted to give the man medication intravenously (into the vein), but after several attempts was unable to insert a cannular (tube) into his vein. She then injected adrenaline directly into his muscle. The paramedics arrived and gave him further adrenalin. They administered life saving medication directly into his bone marrow.

The man was taken to University College Hospital, London by emergency ambulance at 9.16am where resuscitation attempts continued. However, at 9.52am he was pronounced dead. The prison contacted the family and subsequently contributed to the funeral costs. A full debrief of staff was held and those involved were offered support.

Concerns about the quality of the roll checks and other matters were drawn to the attention of the Governor by my investigator and I am satisfied that this matter is being dealt with internally.

I make five recommendations, relating to the assessments conducted on prisoners arriving into custody and monitoring procedures on F wing.

THE INVESTIGATION PROCESS

1. The investigation was opened by my investigator at HMP Pentonville on 15 September, where he was provided with all documentation relating to the man. Notices were issued informing both staff and prisoners of my investigation. They asked anyone who had information pertinent to my investigation to contact the investigator, but no responses were received.

2. NHS Islington was asked to conduct a review of the medical care provided to the man while in custody. The review and subsequent report was completed by the clinical reviewer. I would like to thank him for his assistance. His report is attached in full at annex 1.

3. My investigator wrote to the Coroner to inform them of the investigation and requested a copy of the post mortem report.

4. One of my family liaison officers (FLO), spoke to the man's sister, his nominated next of kin, on 13 October. She explained the role of my office and the purpose of our investigation. My family liaison officer also offered to visit the man's sister at home, so that she could raise any concerns about her brother's time in custody. The visit took place on 25 October.

5. During the visit, my investigator and the liaison officer explained the investigation process in more detail. The man's sister was keen to know about her brother's treatment and medication whilst he was in custody. These concerns are dealt with in the body of my report. The man's sister said that she had been treated well by staff from Pentonville since her brother's death.

6. My investigator visited Pentonville during November to conduct interviews with staff, both independently and jointly, with the clinical reviewer. After he completed the interviews, my investigator discussed the emerging issues with the governor and later confirmed his findings in writing.

The Man

7. The man arrived in the United Kingdom from Georgia on a student visa in November 2003. He was granted further leave to remain in the country in 2004 and 2005, but after this he made no further applications to have his stay validated.

8. Little is known about work or recreational pastimes the man was involved in or enjoyed. In 2007 he spent a period in prison custody. At around the same time, he again came to the attention of the immigration services. An order was made for him to be deported, but he failed to surrender himself and no further attempts to trace him appear to have been made.

9. His sister said that he got involved with the wrong people, used illicit drugs and drank excessively. At times, she had tried to intervene in an attempt to stop her brother using drugs, but this failed.

10. Records show that he was arrested in 2009, on suspicion of illegal entry, but no action was taken and he was again released from custody. This was a frustration to his sister, who said that she felt her brother's best chance of getting free of drugs was to return to Georgia.

HMP PENTONVILLE

11. Pentonville was built over 150 years ago, and serves the London courts. It has an operational capacity of 1,250 prisoners.

Healthcare

12. 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 services (including the inpatients unit), and Barnet, Enfield and Haringey Mental Health Trust provides psychiatric care.

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

Drug and alcohol treatment

14. Pentonville has an Integrated Drug Treatment Service (IDTS) on F wing. IDTS aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on early custody, improving the integration between clinical and Counselling, Advice and Throughcare (CARAT) Services and reinforcing continuity of care from the community into prison, between prisons, and on release into the community. Prisoners identified as having drug or alcohol problems are located on F wing generally and begin treatment. As their individual treatment progresses they will move through varying stages of the wing before finally being located to a normal residential wing.

Previous deaths at Pentonville

15. This is the 19th death at Pentonville that my office has investigated since becoming responsible for investigating all deaths in prison custody in April 2004. There have been another two deaths since the man died. The issues in this investigation include concerns similar to those raised in earlier investigations, including staffing on the IDTS wing, and following healthcare protocols. I have previously recommended that NHS Islington ensures that staff complete clinical observations in accordance with their protocol. In addition, that the service manager and head of healthcare should assure themselves that the observations were being completed.

Her Majesty's Chief Inspector of Prisons (HMCIP)

16. The Chief Inspector of prisons led the most recent inspection of Pentonville in May 2009. With regard to healthcare, the inspection found:

> "There had been considerable improvement in some healthcare areas, but continuing work was needed to modernise the overall service. There was excellent support from the Islington Primary Care Trust. Primary care services were improving slowly, but more nurse clinics were needed. There was good access to GPs and waiting lists for visiting health professionals were well managed. Dental services were improving and pharmacy services were good. The management of external NHS appointments was commendable. The regime for inpatients was only basic and care plans were poor."

17. In relation to drug and alcohol intervention and services:

> "Interventions available included counselling, assessment, referral, advice and throughcare (CARAT) group work modules, the short duration programme (SDP), the prisons – addressing substance-related offending (P-ASRO) course and self-help groups. There were no services or strategy for those with alcohol problems. There was good throughcare support and drug intervention programme (DIP) officers were available to support prisoners from local boroughs."

Independent Monitoring Board (IMB)

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

19. The latest IMB report covered the period from 1 April 2009 to 31 March 2010. It noted that:

> "The new Health Service provider, a consortium led by NHS Islington, started on 1 April 2009. For various reasons, they have struggled to fill a significant number of vacancies. The post of lead GP was vacant for 10 months. Agency nurses were hampered by having no keys." (it is believed that this refers to agency nurses not being to access all parts of the prison unescorted.)

In this report, I make a recommendation in respect of filling healthcare staff vacancies.

20. The IMB also commented on F wing (IDTS) and wrote:

> "After long delays, F Wing opened in July 2009. An initial shortage of nurses has been resolved, and the IDTS appears to run well. However, the numbers being treated are far greater than those planned

for, or funded by, the Primary Care Trust – up to 250 prisoners at a time, with only 120 beds on F Wing. The effect of this on E Wing has been noted (see above). Whether the IDTS can continue to be well run and funded under these pressures is a matter of serious doubt."

KEY EVENTS

21. The man was arrested on 8 September and taken to Chingford Police Station where he was charged with theft from a shop. While in police custody, the duty doctor assessed him and confirmed that he was fit to be held at the police station. No concerns about his physical health were recorded but, on the medical form used by the police, it is indicated that he was given 30mg dihydrocodeine (opiate based pain killer), 5mg diazepam (widely used to treat acute alcohol substance misuse treatment) and 5mg prochlorperazine (commonly used to treat symptoms of mental illness, but also used in smaller doses to treat nausea, dizziness or vomiting), in the early hours of 9 September.

22. Later on the morning of 9 September, the man appeared at Waltham Forest Magistrates Court where he was convicted and sentenced to 12 weeks imprisonment. Following his court appearance he was taken by escort staff to HMP Pentonville. This was his second period in custody, he had previously been at Pentonville in 2007. He was 35 years old.

23. On arrival at Pentonville, he was taken through the normal reception procedures. These included providing next of kin details, height, weight and previous custodial history. In addition, his property was recorded and stored and, as a sentenced prisoner, he was required to wear prison clothing. Once the reception procedures were completed, he was taken to A wing which is also the first night centre. The first night centre aims to create a relaxed atmosphere for prisoners, where staff will interview prisoners to provide and obtain information from them. This process includes the completion of a cell sharing risk assessment (CSRA). While on the first night centre, prisoners are also seen by nursing staff, including substance misuse treatment staff and the duty doctor.

24. The CSRA is a nationally used document to assess the suitability of a prisoner to share a cell. It consists of a series of questions that are asked of the prisoner. These include information on previous behaviour in custody, homophobic or racially motivated offences and other reasons why they feel they would not be able to share a cell. Based on the answers provided, the prisoner will be assessed as high, medium or low risk. High risk means that they are unsuitable to share a cell as they potentially pose a risk to cellmates, low risk that they can share and medium risk would be at discretion of the duty manager. However, healthcare staff also complete a section of the CSRA, based on medical status of the prisoner. If it is known that they are suffering from a serious medical condition or mental health problems, nursing staff will assign a risk category accordingly. The level of risk assigned by the nursing staff, if higher than that completed by the officer, will be the one that is followed.

25. An officer interviewed the man when he arrived on the wing, and completed the initial part of the CSRA. The officer told the investigator that there would be around three or four other staff on the first night centre conducting various stages of the process. He said that his involvement with the man was limited and, apart from the CSRA, he did not complete any other documentation.

26. On the CSRA, the officer wrote “Russian prisoner, very little English and may require interpreter”. When asked whether this was his view of the man or information he had gained from other documentation, he said that he would write any concerns he had on the CSRA to help the next person who dealt with the man. The officer was asked whether he recalled his conversation with the man and whether he felt that the questions he was asking were understood. He explained that he was unable to recollect the particular conversation with the man. The investigator then asked in more general terms about the facilities available for staff to use with foreign national prisoners. The officer explained that staff are able to use a service called ‘Language Line’ that provides interpreting services and the interpreter will act as a go between over a telephone line. He also said that in some cases, there may be other prisoners or occasionally members of staff who are able to communicate with a prisoner. Prisoners are provided with written information on the first night centre telling them about rules and the daily regime of the prison, as well as services available to them. The officer said that this information is available in a number of languages.

27. Once the man had completed the CSRA with the officer which identified him as a low risk and suitable to share a cell, he was taken to see the Healthcare Assistant (HCA) who completed the initial health screen. During the health screen, the HCA identified that the man would need to be assessed by the substance misuse nurse. When interviewed the HCA was asked how long the assessment took as the timings on the medical record indicated that it was around eight minutes. It is recorded that the man was seen by the HCA at 6.42pm and assessed by the doctor at 6.50pm, and in between this he had been assessed by the substance misuse treatment nurse. The HCA agreed that these timings did seem “a little odd.” There was also a discrepancy in the recording of his ethnicity, which had been ticked as “white British” even though he was clearly a foreign national.

28. On her record of the assessment with the man, the HCA recorded “interpreter needed”. She said that as it had been recorded as “may be required” by the officer who had interviewed the man when he arrived on the wing if one was available then it would be advisable. However, she added that, in her opinion, the man was able to understand all the questions he was asked, although it took him longer to respond to some. In addition to stating that he was an intravenous drug user, the man also told the HCA that he was hepatitis C.

29. Hepatitis C is an infectious disease affecting the liver, caused by the hepatitis C virus (HCV). The infection often has no symptoms, but once established, chronic infection can progress to scarring of the liver (fibrosis), and advanced scarring (cirrhosis) which becomes apparent after many years. In some cases, those with cirrhosis will go on to develop liver failure or other complications, such as liver cancer or life threatening esophageal varices (enlarged veins) and gastric varices. The hepatitis C virus is spread by blood-to-blood contact. Those, like the man, who have injected drugs are at increased risk of getting hepatitis C because they may be sharing needles or other drug equipment.

30. In response to her questions about depression or mental illness, the man replied that he had depression. When she explored any thoughts of suicide, he replied “not at the moment”. The HCA said that this concerned her as it may have previously been an issue. When she explored this further, he told her that he had previously cut himself. Despite the man telling the HCA that he had previously harmed himself and that he appeared in a depressed mood and said he felt depressed, she said that at the end of her assessment she ”had no concerns”. The HCA referred him to the substance misuse treatment nurse and made an entry that he should be admitted to the substance misuse treatment unit.

31. A substance misuse treatment nurse who reviewed the man almost immediately after the HCA had completed her assessment. She said that she was able to communicate well with the man and, although his English was not perfect, he understood the questions he was asked. As previously mentioned, when the man arrived at Pentonville the documentation that had been passed on by the police, including the treatment card, was handed to prison staff. The substance misuse treatment nurse said that she did not see this during the assessment, but it is something that she would have expected to be given, so that she would know what medication the man had been prescribed.

32. During his assessment with the substance misuse nurse, the man asked to be maintained on methadone (used in the treatment of opioid dependence). The nurse was asked to describe the process to be followed to place a prisoner on methadone maintenance. She replied that she would find out as much as she could about how much he had been using in the community and what services provided him with his prescription. Once the prisoner has seen the substance misuse doctor they can be titrated (tested to assess the levels of medication in their system). The nurse said that this is done as soon as possible so that proper treatment could begin.

33. The man had not been prescribed methadone in the community and had been using various illicit drugs and alcohol to excess. The substance misuse nurse recalled that the man had told her he was injecting intravenously into his thigh. They also discussed alcohol and she said that the substance misuse treatment from alcohol was her greatest concern at that time. During the assessment process, the man indicated that he used heroin, cocaine, crack cocaine and benzodiazepines. In addition, the substance misuse nurse recorded that his alcohol consumption was five to seven cans of strong cider and one to two bottles of wine daily. He told the nurse that he had been drinking since he was 30 years old, and at these levels for the past 18 months.

34. The substance misuse nurse’s assessment to determine the level of the man’s withdrawal was done in two parts. Firstly, she used the opiate withdrawal observation chart. This gives a list of symptoms and the nurse is required to assign each with a number ranging from 0 to 3 if they have been experienced by the prisoner in the last 24 hours. The numbers represent 0 = none, 1 = mild, 2 = moderate and 3 = severe. On the scale, the nurse assigned each symptom with a 3, indicating that they were severe. She also recorded his pulse rate 71bpm, blood pressure 107 over 75 and his pupil size as 4mm. These

readings would identify that the man's pulse rate was within normal range and, his blood pressure was normal, although on the lower side.

35. The second part of the assessment is to assess alcohol withdrawal. It starts with a series of ten questions about nausea, tremors, sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headaches and orientation. Each question has answers ranging from 0 to 7, with 0 indicating no symptoms. The man indicated by his answers that he had moderate tremors in his arms, barely perceptible sweating was moderately anxious, had some agitation and a slight headache. He said that he had none of the other symptoms. The total score is then added together and used to determine the severity of the withdrawal. A score of ten or under is mild, 10-20 is moderate and 20 or over is severe. The man had a score of 13.

36. The next page of the assessment is again for alcohol but also benzodiazepine withdrawal. The top part is for the nurse to record pulse rate (both lying down and standing) and blood pressure (lying and standing) but these were not recorded. The rest of the page again assigns a score to symptoms such as nausea, stomach cramps, vomiting etc, on a scale of 0 to 3. The substance misuse nurse recorded the man as being either moderate or severe on all symptoms, apart from diarrhoea and distorted perception which were given a score of 0. This is in contradiction to the score previously completed. The nurse completed her assessment by recording that the man should be seen by the reception GP.

37. When asked about the differences between the scores, the substance misuse nurse said that she recorded the response from the man rather than her own observations. She said that there were no obvious signs of withdrawal despite her scores and he sat quietly throughout the assessment. The investigator asked the nurse whether she had discussed with the man any thoughts of suicide or self-harm. He had mentioned that he felt "low in mood" which she recorded in his medical notes. The nurse said that she advised the man that if he was feeling like this then there were people who he could speak to in the prison, such as the chaplains. The nurse was asked by the clinical reviewer whether she asked the man directly about being suicidal, and she said that she had but he was not "forthcoming".

38. As a dual diagnosis (mental health and substance misuse) nurse and therefore familiar with the regime on the substance misuse treatment unit, the investigator asked the substance misuse nurse about the requirements observing a prisoner on the unit, particularly when first located. The nurse thought prison officers checked them every 30 minutes, and that the night nurse may make entries on the medical record, but prison officers would do the visual checks. In fact, Pentonville Healthcare has a policy which sets out the duties of the night nurse. One of their duties is to perform regular checks on newly admitted patients, hourly for the first two hours and then every four hours, unless more frequent observations are required. The checks should be on all patients within the first 72 hours of admission to F wing, particularly, newly-admitted alcohol and benzodiazepine dependent patients.

39. Following the substance misuse nurse's assessment, the man was assessed by a prison doctor. She has been a GP at Pentonville since January 2008, working from Monday to Friday and occasionally covering reception where she reviews new prisoners as they arrive into custody. The prison doctor said that she could clearly remember the man and there was nothing unusual or alarming about him. He was calm, and although he did not speak perfect English, it was clearly enough for him to be able to communicate. She felt that he understood fully the questions he was being asked.

40. The prison doctor said she asked the man about his drug misuse, the hepatitis C that he had disclosed to the HCA and whether he had ever been referred to a specialist. He told her that he had not. The doctor completed a form for a blood test in order to confirm the hepatitis and to enable her to make an onward referral. The doctor said that the man gave her the impression that he would be at Pentonville for quite a while. If he was only going to be there a few weeks, she said that a referral would have been pointless. She added that his hepatitis was the only thing that she felt required medical attention that evening.

41. The prison doctor confirmed that by the time she saw the man, a full drug and alcohol screening had been completed by the substance misuse nurse and the doctor recorded that he had "no objective forms of withdrawal". When asked what types of things she would expect to see in a patient who was withdrawing, the doctor listed retching, runny nose, feeling nauseous or jittery, but in her opinion, the man had none of those symptoms. The clinical reviewer asked whether showing any of those symptoms would have changed the way in which the man was managed. The doctor explained that the current protocol at Pentonville does not allow for this. She said that if a prisoner arrives and is already on a methadone prescription then this would be continued. However, if not, they are prescribed supportive therapies as the man was, which is symptomatic relief for the first night. They would be seen by the substance misuse treatment doctor the following morning. The doctor confirmed that Pentonville does not operate first night prescribing. (First night prescribing refers to the system in some prisons where the healthcare services begin methadone therapy on the first night that a prisoner is received into custody.)

42. In explaining the process at Pentonville, the prison doctor said that on occasions some prisoners arrive into custody with a prescription of methadone that they received in the community. In these cases, the prescription will have the name of the pharmacy, which dispensed the drug, which would enable her to give the prisoner 10mls on the first night. The doctor said that the medical team at Pentonville are keen to introduce first night prescribing and that a regular team of doctors is now in place so this may happen in the future.

43. During her assessment with the man, the prison doctor asked him about any suicidal thoughts or mental health problems he had now or in the past. He had not disclosed anything to her, but had she been concerned about him then she would have the option of starting Assessment, Care in Custody and Teamwork (ACCT) monitoring. ACCT is used to monitor and support those considered at increased risk of either suicide or self-harm. The doctor said that she had no concerns about the man who did not show any signs of distress.

44. The investigator asked the prison doctor whether she had sight of the drug and alcohol score completed by the substance misuse nurse, and whether she was aware of the scores the nurse had allocated in relation to withdrawal. She replied that she would not have seen the document and was unsure how it was completed. She confirmed that the man had not displayed any signs of withdrawal during the consultation that she had with him. She prescribed treatment for his alcohol withdrawal and symptomatic treatment for drug misuse. The medication provided was chlordiazepoxide 20mg (to help relieve the symptoms of acute alcohol withdrawal), metoclopromide 10mg (commonly used to treat nausea and vomiting), hyoscine butylbromide 20mg (for relief of abdominal pain), loperamide 4mg (for relief of diarrhoea) and ibuprofen (relief of cramps). All the medications were prescribed and given to him before he was taken to F wing (IDTS unit).

45. When prisoners first arrive on F wing it is usual practice for them to be located in a cell on the top landing (F5). As they progress through their treatment, prisoners gradually move down the landings before eventually being discharged and moved to a normal residential unit. However, on the evening that the man arrived (9 September) no spaces were available on F5 and he shared a cell on F3 landing.

46. The night duty officer working on F wing went to the wing at around 11.00pm. When asked about the routine on F wing, the night duty officer said that if there are prisoners on the wing who are subject to ACCT or have other problems such as depression she would be told about them by the outgoing day staff. She said that the checks on these prisoners could be anything from every 30 minutes to every four hours. However, if nothing was highlighted she would not be required to carry out any regular observations during the night. In addition to knowing which prisoners required closer monitoring, the night duty officer said that she should also be made aware of the new receptions.

47. During the investigation, the safer custody manager, told the investigator that the prison has magnetic signs that staff could place on cell doors. These signs are different colours and identify new receptions, those on open ACCT documents or other reasons someone may require closer monitoring. The safer custody manager said that he was under the impression that staff had access to these, and he would ensure that all areas of the prison began using them where necessary.

48. As mentioned, the man was not located on F5 as would normally be the case for new receptions and the night duty officer was asked whether this would have made a difference. She considered that if the man had been located on F5 or even F4, which is the normal “overspill” landing, she would have looked in on him when she carried out her nightly checks as she also randomly checks the cells of those who are newly arrived. However, as the prisoners that are generally located on F3 have been on the unit for a while, she would not check them unless they were subject to special monitoring.

49. The night duty officer said that she had no need to go to the man's cell during the night and could not recall seeing him during her duty. She said that the night of 9 September was busy as a prisoner located on the unit was causing problems and she spent a great deal of her time out on the landing. The night duty officer confirmed that there is no policy that requires her to check all new prisoners on F wing who have just begun substance misuse treatment treatment.

50. In addition to the officer, there is also a night nurse on F wing in the treatment room. On the evening of 9 September. The night nurse completed a statement in which she said that she had arrived for duty at 8.45pm, and had been given a handover from the substance misuse nurse, who told her that she had completed assessments on two prisoners, the man and one other. The night nurse spoke to the man and his cell mate for around ten minutes. There were nine admissions that night and the night nurse said that she had no concerns about any of them. She could recall seeing the man when he was brought onto F wing later in the evening. She thought that he appeared all right and was talking with his cell mate.

51. In her statement, the night nurse says that she was not inducted when she began work on F wing and was not told that she was required to check new admissions every hour, despite the policy (previously mentioned) that clearly states this is part of the night nurses' duties. The night nurse said that the only patients she would check hourly would be those on ACCT monitoring or with a history of self-harm.

52. The service manager responsible for substance misuse and mental health at Pentonville, was interviewed by the investigator and the clinical reviewer. They asked for her view of the monitoring which should take place on F wing. The service manager said that new admissions can come across to the unit anytime up until when the reception closes, which can be around 11.00pm. The night nurse firstly gets a handover from the evening nurse, and then their primary focus will be on observing new admissions. Not all observations would be the same as it would depend on how well the patient was doing. If someone is in discomfort from withdrawing, the level of observation will be higher than someone who settles quickly.

53. The service manager was asked why the night nurse was not inducted or made aware of the policy, which clearly sets the requirements for monitoring new receptions on F wing. She replied that the policy was expanded in March 2010 and she believed that the requirements for night nurses had been communicated to all her staff. She said that the night nurse had been working on F wing for six months and there had clearly been a breakdown in her induction. The service manager said that she believed observations by night nurses were not being recorded prior to the man's death and this should have been done. When asked for her opinion of what observations should be carried out, the service manager said that it should be hourly for the first four hours up to around 2.00am, and then if the patient is stable she would expect the nurse to reduce the observations to allow the patient to get a good nights sleep.

54. There is no evidence that the man was observed during the night either routinely or for any other reason by either the officer or nurse. The night duty officer carried out a full roll check on F wing between 5.00 and 5.30am. When conducting a roll check the officer will look into every cell via the observation panel and confirm that each cell contains the correct number of prisoners. They will then record the numbers and sign a record, as well as reporting the total number to the orderly officer so that an overall total can be gained for the prison.

55. The night duty officer said that she would have definitely counted the prisoners in every cell, but could not specifically recall the man. She was joined by the early unlock officer, who arrived for duty as the early unlock officer at 6.45am. The s regular start time was 7.15am, but he had decided to come in early. The early unlock officer is responsible for counting the wing that they have been assigned to and after confirming that their numbers are the same as those obtained by the night officer they will be given a handover and the night officer will go off duty.

56. F wing had a roll of 118 prisoners on 10 September, and the early unlock officer was the only unlock officer. The night duty officer said that she briefly spoke to the early unlock officer when he came on duty. He then left the office to count the wing and returned after around ten to 15 minutes and said that he was happy with the roll. The night duty officer confirmed that she gave a handover to the early unlock officer at 6.55am, after he had completed his count. The early unlock officer was asked whether he could recall seeing the man out of bed when he made his count. He said that seeing a prisoner out of bed was something that he would probably recall, but he could not remember seeing the man. He signed for his roll of 118 prisoners at 7.05am.

57. Other staff on F wing began arriving for duty at around 7.30am. Two senior officers briefed all the staff on issues from the previous day and assigned them to their areas of work. The first officer on the scene and the second officer on the scene were detailed to work together on F3 landing. The first officer on the scene made his way to F3 at around 7.55am and, after unlocking the landing cleaners, began letting the other prisoners through to collect their medication. The second officer on the scene was next to the treatment room, monitoring those prisoners. At 8.15am, the first officer on the scene was alerted to the cell call light coming on at cell F3-14, and so he locked the gate and walked along to the cell. When he looked into the cell via the observation panel, a prisoner (the man's cell mate) was standing in front of him, blocking the view of the cell and the officer asked him what was wrong. The prisoner did not say anything, but stepped aside and the first officer on the scene saw the man hanging from the window bars at the back of the cell. (The cell mate was not interviewed during the investigation as he had provided an account to police and prison staff, and the investigator did not consider it necessary to interview him further.)

58. In his statement, the first officer on the scene described the man hanging "free from the floor" and was asked to describe what he meant by this. He said that the man was quite high up in the corner of the window and his feet were off the floor. When asked by the investigator whether it could look as though the man

was standing looking out of the window, the first officer replied that the man was facing into the cell and it was clear that he was hanging.

59. The first officer on the scene opened the cell door and, as he did so, he called along the landing to the second officer on the scene for assistance. The first officer on the scene went into the cell and immediately grabbed the man and tried to lift his weight at which point the second officer on the scene also came into the cell. The second officer on the scene took hold of the man and first officer on the scene stood on the heating pipe that ran along the base of the wall and cut the ligature using his cut-down tool. (Cut down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners must carry their own personal issue tool.)

60. The first officer on the scene was again asked by the investigator whether it was possible that the man's feet may have been resting on the heating pipes, but he was insistent that his feet were clearly about 12 inches above the pipe. Once the officer cut the man free from the ligature, they laid him on the floor. The first officer on the scene administered cardio pulmonary resuscitation (CPR), while the second officer on the scene moved furniture out of the way so that medical staff would have access. While both officers were cutting the man down, another member of staff had radioed for emergency medical assistance. The officers said that the man was very cold and his body was quite rigid. The first officer on the scene described the ligature as having "embedded" itself in the man's neck and, when removed, it left a very pronounced black mark.

61. The first nurse on the scene began to administer breaths to the man whilst the first officer on the scene continued with chest compressions. The second nurse on the scene was the shift co-ordinator that day and had also heard the emergency call and made her way to F3 landing. She quickly assessed the situation and telephoned the substance misuse manager, who is a grade 7 nurse, and was working on E wing that morning. The substance misuse manager said that she did not have a radio that morning, but after the call from the second nurse on the scene she went directly to F3.

62. When she arrived, the substance misuse manager made a quick assessment of the man. She said that his pupils were fixed and dilated (unresponsive and the pupil is open), he was quite cyanosed (blue colouration of the skin) and there were no attempts to breath. The substance misuse manager also checked for a pulse and none was present in the radial (radial artery felt in the wrist), carotid (felt in the right side of the neck) or the femoral (femoral artery felt in the groin). She then assisted with CPR, and also tried to cannulate the man. (Cannulate means to insert a cannular (tube) into the body to administer medication.) The substance misuse manager tried to do this twice but could not get the cannular in and decided to administer adrenalin into the muscle.

63. As the substance misuse manager was doing this, the emergency paramedics arrived. The time was now 8.25am. The paramedics inserted a tube into the man's airway and the substance misuse manager gave another intra-muscular injection of adrenaline. Because a cannular could not be inserted into the man, she said that the paramedics then carried out a procedure where they drilled

into the bone marrow to administer fluids that way, but there was still no response from the man. The defibrillator was also attached to the man but it advised that there was no shockable rhythm and CPR was continued. (A defibrillator is a machine that can restore normal heart beat by applying a brief electric shock, but will only work if a heart rhythm is detected.) The man was placed on a stretcher by the ambulance crew and CPR continued onto the ambulance, where the substance misuse manager and other nursing staff handed over to the paramedics.

64. The clinical reviewer asked the substance misuse manager for her opinion of how long she felt the man had been hanging. She explained that she had carried out many resuscitations in her long nursing career. In her opinion, the man was in a state of rigor mortis when she treated him. Rigor mortis refers to the stiffening of muscles after death. The investigator was aware that the substance misuse manager had mentioned the man's condition to other members of staff, and asked her about this. She said that in her opinion the man had been hanging for more than an hour because when she injected in his upper leg and arm the blood was "black". She explained that this indicated that it was de-oxygenated and she considered it would take more than an hour for this process to happen. The other indication, which influenced her opinion, was the fact that the discolouration of the blood was the same when taken from the bone marrow in the man's leg by the ambulance staff. The clinical reviewer has provided additional information on the issue of rigor mortis in his report.

65. The man continued to receive treatment from the paramedics in the ambulance and was taken to University College Hospital, London. Two members of prison staff escorted the man, but no restraints (handcuffs) were used. The ambulance left the prison at 9.16am.

66. The prison telephoned the man's sister, his nominated next of kin. They told her what had happened to her brother and arranged for a taxi to collect her from her home address and take her to the hospital.

67. At the hospital, the man was taken straight to the resuscitation room where efforts to revive him continued. Sadly, at 9.52am, the escort staff contacted the prison and told them that the man had been pronounced dead. Unfortunately, his sister did not arrive at the hospital in time and arrived shortly afterwards.

Actions following the man's death

68. The prison held a full debrief of the staff who had been involved in treating the man and the officers that had been first to attend to him. They were also offered support by the staff care team. In addition, the man's cell mate who had raised the alarm was provided with support from the chaplaincy team and Listeners. (Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.).

69. Prison staff contacted the man's sister by telephone and in writing and arranged for all his belongings to be made available. The prison also made arrangements for a contribution towards the funeral expenses.

70. A critical incident debrief was held a few weeks later, facilitated by Prison Service Employee Support. It enabled all staff involved to discuss how they are feeling and whether they felt the support immediately after the man's death was appropriate.

ISSUES

Medical assessments on reception

71. As part of the reception process, the man underwent several assessments. In many respects, the process, content and timing of the assessments are inconsistent and difficult to follow and it is hard to understand how individuals reached their conclusions. The HCA, who completed the initial health screen, said that she entered the man's responses onto the EMIS (the clinical computer system) as the assessment was taking place. According to the timings recorded on the system, this would mean that in the space of eight minutes the man had been subject to a detailed initial health screen, a full alcohol and drugs assessment carried out by the substance misuse nurse and a review by the prison doctor.

72. In response to my draft report, HMP Pentonville have said that when the prison doctor made her first entry on the EMIS system it was only to triage the man and that at that time he was not with her. However, this was not mentioned by the man when she was interviewed. Also, the prison has said that the timings only represent the time taken to write entries onto the system and not the length of a consultation. While I am grateful for the clarification on this, nursing staff were interviewed and could have explained the process to the investigator, thus avoiding the confusion.

73. The scales completed by the substance misuse nurse during her assessment are also somewhat contradictory. In some, they rate the man as having severe nausea and in others an absence of nausea. Her assessment also reports him as having moderate to severe withdrawal symptoms yet all three healthcare professionals note that he had no obvious signs of withdrawal during their individual examinations. During interview, the substance misuse nurse attributed the discrepancies to contradictions between the man's responses and her own observations.

74. An internal review completed by Pentonville healthcare managers following the man's death, noted the lack of time for assessments within reception as a contributory factor. The clinical reviewer refers to this in his report and says.

> "It is self-evident that if the Foundation Trust are of the view that the content of the assessment is essential to the safety and well being of the patients, then a review of the available resource, or of the processes which support the assessments (in this example 3 separate staff made assessments without much of the content being available to the most qualified) should take place as a matter of urgency."

In respect of this issue, the clinical reviewer makes the following recommendation, which I am happy to endorse:

The Head of Healthcare and Service Manager for substance misuse should review the assessment processes and available resources to ensure that staff have sufficient time to carry out full assessments within the reception/first night centre of the prison.

Observation of prisoners on F wing substance misuse treatment unit

75. The man was given a cell on F3 landing when he arrived on F wing. The investigator was told that it would be normal practice for a new prisoner to be allocated to F5. The nurse would then checked them hourly for the first four hours and then reduce the observations on an individual basis.

76. Staff said that the man was sent to F3 due to lack of available space on F5. There is no evidence of checks being made of the man during the night. The night nurse said that she had had no induction and was unaware that she had to check patients frequently, unless they were subject to ACCT procedures. The service manager for substance misuse and mental health assured the investigator and clinical reviewer that a clear policy was now in place. However, in interviews, the investigator received a number of mixed messages about what was expected of the nurses during the night and the processes that they were expected to follow. In his review, the clinical reviewer has provided a table which highlights these discrepancies, I attach this below. It clearly demonstrates that seven different members of staff gave seven different interpretations.

Name/grade	**Frequency of Observations**	**Other information**
Second officer on scene	No special observations	First night prisoners are identified by landing lists
Night duty officer	No formal checks but check random cells on F4 and F5 whilst pegging	
Service manager	1 hour checks for the first four hours then as required. Looking to introduce documentation for this.	
Wing manager, Substance misuse	2 hourly until they are settled then again in the morning. Observations recorded in EMIS (electronic patient record)	First night patients identified by a green magnetic strip on the door. Patients on a ACCT an Orange strip
Charge Nurse Substance Misuse	Half Hourly with Prison officers Documented in EMIS	
Second officer on the scene	Not known what nursing staff do.	Officers need to 'peg' certain parts of the landing every ½ hour
First officer on the scene	Healthcare do the observations	First night prisoners identified with a sticker on the door

77. In response to my dra

ft report HMP Pentonville have said that the service manager has commented that the documentation was introduced in March 2010, but does not appear to have been systematically implemented to all staff by the former manager.

78. The night nurse was a regular 'bank nurse' rather than a permanent member of staff. (A bank nurse will be recruited from an agency on a needs basis.) The report completed by the healthcare managers notes a high usage of bank staff in the unit and, as mentioned earlier in my report, the IMB had reported this as a matter of concern. The clinical reviewer said that this is likely to give the management team difficulty ensuring that staff know what they are expected to do to ensure patient safety.

79. Both the frequency and purpose of the checks was unclear to both officers and healthcare staff. The clinical reviewer has pointed out that, if the purpose of the checks is for suicide prevention, it is unclear what routine hourly visual checks would achieve, and if this is a concern for a particular prisoner then ACCT procedures should be in place. The clinical reviewer also concludes that it is difficult to assess withdrawal symptoms without direct access to the patient, as is the case at night. Nevertheless, if they are deemed important to the safety and wellbeing of the patients, then clear expectations of staff should be made both regarding the number and recording of such checks.

80. The clinical review makes a number of recommendations on the issue of staff awareness of policies, which I have slightly recast and fully endorse:

The Foundation Trust should fill all vacant posts as soon as possible to provide continuity of care provided.

The Head of Healthcare and Service Manager for substance misuse should clarify with both nursing staff and prison officers the expectations and purpose of any observations.

The Head of Healthcare and Service Manager for substance misuse should make clear the arrangements for documenting observations and conduct audits to ensure they are completed appropriately.

81. During the investigation, the investigator was told that magnetic labels were available to staff that could be placed onto cell doors to alert them that the person occupying that cell was either a new reception, on an ACCT or required regular checks. Although I understand that these may now be in regular use, I make the following recommendation:

The Governor should issue a Notice to Staff highlighting the availability of magnetic labels for cell doors and providing clear guidance on when they should be used. In addition, he should ensure that there are adequate supplies on each wing.

Roll checks and the discovery of the man

82. The night duty officer completed her morning roll check between 5.00 and 5.30am, but does not recall seeing the man during that time. Early unlock officer arrived for duty at 6.45am and, after a brief conversation with the early unlock officer went to count the prisoners on F wing. The early unlock officer said that he returned around ten minutes later. She then handed over to him at 6.55am and left the wing. It's recorded as signing for a roll of 118 prisoners at 7.05am.

83. My investigator had concerns regarding the length of time the man had been hanging before being discovered. The substance misuse manager believes that he had been dead for more than an hour before he was found at 8.15am. However, both officers were insistent that they had definitely conducted a full count of every cell on F wing, and neither could recall seeing the man or anything untoward in his cell. The man was discovered within 70 to 80 minutes of the early unlock officer's last roll check.

84. The investigator interviewed a number of staff who had been involved in treating the man. Their accounts raise a question about how long he had been hanging prior to being discovered by his cell mate. The clinical reviewer also provided in his report a table that shows the discrepancies between the different accounts, which I attach below:

Name	Description
First officer on scene	'Stone cold' and white. Not stiff but he wasn't flexible. Ligature was embedded in his neck
Second officer on scene	Cold to touch. Quite rigid, quite stiff and definitely grey
Substance misuse nurse	Very cold, dilated pupils
Substance misuse manager	Pupils fixed and dilated. Cyanosed and no attempts at breathing. No pulse, no radial, no carotid, no femoral. His arm was rigid, he was cold to touch, and he was mottled. He was in a state of rigor mortis. When I injected him in his upper leg and his upper arm, the blood that came up was a black jelly and de-oxygenated.

85. Neither I, nor the clinical reviewer are qualified to determine the time of the man's death, but given this was raised during the investigation we are obliged to investigate this as fully as possible. The clinical reviewer was able to research this area and provides information within his report. I attach the table below which indicates approximate times of death in relation to the body.

Approximate times for algor and rigor mortis in temperate regions		
Body temperature	**Body stiffness**	**Time since death**
Warm	Not stiff	Dead not more than three

		hours
Warm	Stiff	Dead 3-6 hours
Cold	Stiff	Dead 8-36 hours
Cold	Not stiff	Dead more than 36 hours
Source: *Staerkeby, M. 'what happens after death?' In the University of Oslo Forensic Entomology.*		

86. This table suggests that the man had been dead for at least three hours prior to being discovered at 8.15am. This, however, is in conflict with the statements and interviews of both the night duty officer and the early unlock officer who, both describe checking all the cells as part of their respective roll checks. While there is no evidence to suggest that the officers did not conduct the roll checks as stated, there were 118 prisoners on F wing, over five spurs and the roll check conducted by the early unlock officer was completed in ten minutes. It is hard to imagine how the checks were conducted so quickly and given the speed, I question the quality and thoroughness of the checks.

87. At the end of the investigation, the investigator shared the concerns raised about the roll checks with the governor, the governor said that an internal review into the quality of the roll checks undertaken at Pentonville would take place and I therefore make no further recommendation on this issue.

Resuscitation attempts

88. The clinical reviewer has reflected on the resuscitation attempts within his review and says "all the descriptions of the attempts at resuscitation by both the Healthcare staff and the officers correlate with best practice guidelines and I am confident that no further efforts could have been made to save the man by the staff involved". I concur with his view. In spite of the man's condition, staff clearly made every attempt to revive him.

CONCLUSION

89. The man had a history of both chronic drug and alcohol abuse prior to coming into custody. On arrival at Pentonville, he had all the assessments that would be expected for someone with this history and identified need. However, the quality and sharing of the information obtained and the provision for keeping at risk prisoners safe are questionable. It is clear that the policies, which support the safe delivery of care within F wing, were not followed, either due to insufficient resources or due to insufficient knowledge.

90. While a direct link cannot definitely be made between the absence of regular checks and the man's death, I am concerned about the confusion as to the purpose, regularity and responsibility for conducting such checks.

91. The description given by all the staff involved in attending to the man describe him as cold and stiff suggesting that death occurred in excess of three hours of him being found at 8.15am. However, both the night duty officer and the early unlock officer describe checking all the cells within that timeframe and noticing nothing unusual. Although this calls into question the quality of staff checks, there is nothing to suggest that earlier intervention would have resulted in a different outcome, and the resuscitation attempts by prison officers and healthcare staff met all the best practice guidelines.

RECOMMENDATIONS

1. The Head of Healthcare and Service Manager for substance misuse should review the assessment processes and available resources to ensure that staff have sufficient time to carry out full assessments within the reception/first night centre of the prison.

   The Prison Service has partially accepted this recommendation and said:

   "All assessment processes are in the process to be reviewed due to the move from EMIS to System 1 in the coming months.

   We have noted inaccuracies in the timings noted in the report.

   Healthcare works within the timelines allowed by the prison regime and all assessments have been developed and are compliant with Offender Health guidance."

2. The Foundation Trust should fill all vacant posts as soon as possible to ensure continuity of care provided.

   The Prison Service has accepted this recommendation and said:

   "The Foundation Trust HR department is currently reviewing the situation re vacancies. The vacancies are being covered by bank staff currently, however we acknowledge the need to fill these on a permanent basis quickly."

3. The Head of Healthcare and Service Manager for substance misuse should clarify with both nursing staff and prison officers the expectations and purpose of any observations to be carried out.

   The Prison Service has accepted this recommendation and said:

   "An operational memorandum will be sent to all substance misuse staff making the action point clear with ***immediate*** *effect.*

   New operational policy including movement's guidance to be developed and shared with health and prison staff."

4. The Head of Healthcare and Service Manager for Substance Misuse should make clear the arrangements for documenting observations and conduct audits to ensure they are completed appropriately.

   The Prison Service has accepted this recommendation and said:

   "Memorandum to be sent to all staff outlining expectations regarding standards of record keeping.

   Guidance on record keeping is to be reissued to staff.

Record keeping audits to be undertaken on a monthly basis."

5. The Governor should issue a Notice to Staff highlighting the availability of magnetic labels for cell doors and providing clear guidance on when they should be used. In addition, he should ensure that there are adequate supplies on each wing.

   The Prison Service has accepted this recommendation and said:

   "A Notice to Staff has been issued."