PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

# Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Pentonville in December 2010

**Report by the Prisons and Probation Ombudsman for England and Wales**

**November 2012**

This is a report of an investigation into the death of a man at HMP Pentonville. I extend my condolences to his family and his friends and hope this report answers the questions they may have.

The investigation was carried out by a Senior Investigator. A clinical review was conducted by a clinical reviewer on behalf of the local Primary Care trust (PCT). The final report was received on 7 November 2011. The investigator and the clinical reviewer had significant difficulties arranging interviews with healthcare staff which hampered the completion of the report. I apologise for the delay in this report.

The man told healthcare staff that he wanted to kill himself and was described by many staff as having "bizarre behaviour". He was assessed as a risk to himself and others because of this and was given a single cell on his first night at Pentonville. He was also made subject to a suicide and self harm procedures and made subject to a constant supervision for the first two hours of his imprisonment and again on Sunday 12 December when he harmed himself.

On Monday 13 December, while still on constant supervision by healthcare staff, the man complained of heart pain. Healthcare staff attended but did not treat him because of his aggressive manner. He was later found collapsed and unresponsive by a discipline member of staff who had temporarily taken over the constant supervision, when the nurse went for some water.

While the investigation found that the emergency response to the man was adequate, a number of failings were also identified with the care provided to him at Pentonville. A number of recommendations are made to address these issues, one of which, concerns the need for gated cells for those on constant supervision - a recommendation also by HM Chief Inspector of Prisons in 2009. Other recommendations relate to the need to: improve ACCT procedures, safely manage access to razor blades by prisoners at risk of self-harm, expeditiously issue prescribed medication, ensure prison doctors can access outside telephone lines, improve mental health examinations and ensure appropriate reception processes when dealing with prisoners whose first language is not English. Finally, recommendations are also made that Pentonville ensures that all staff working at the prison provide full and timely co-operation with my investigators which was, unhappily, not the case on this occasion.

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** **October 2012**

**CONTENTS**

## SUMMARY

1. The man was arrested and remanded in custody to HMP Pentonville on 10 December 2010. During his reception into prison he allegedly assaulted a member of staff. He was restrained and taken to the segregation unit, where he spent a short period of time.

2. While he was in the segregation unit, he was made subject to suicide and self harm procedures (known as ACCT) as a prison doctor thought this best in the circumstances.

3. At his healthscreen on reception to the prison, the man presented as agitated and unco-operative. However, the doctor was able to note that he suffered from ischaemic heart disease. She was unable to identify the medication he was taking but prescribed him a GTN spray (used for the symptoms of angina) for him to keep in his possession. This was not given to him by healthcare staff.

4. Over the weekend that the man was in Pentonville, staff said that he displayed bizarre behaviour and continually said that he wanted to kill himself. He cut his arms with a razor blade that he found and was then made subject to a constant supervision, whilst still on the suicide and self harm procedures. (Constant supervision is when a member of staff, either healthcare or discipline staff continually observe a prisoner when in and out of their cell and around the prison.)

5. Several days later, whilst still subject to a constant supervision by healthcare staff, the man said that he was having a heart attack. When healthcare staff attended, he was allegedly aggressive and threatening and the nurse refused to treat him until he calmed down. The investigator has been unable to interview the nurse who attended and has not been able to confirm the exact sequence of events.

6. After approximately half an hour, the healthcare staff member asked a Senior Officer (SO) to take over the constant supervision whilst she went for some water. The SO checked on the man and called for assistance when she found him to be unresponsive. Healthcare staff were called but were unable to resuscitate him and he was pronounced dead at 8.18am.

7. We make 12 recommendations. These concern gated cells, ACCT procedures, access to razor blades by prisoners at risk of harming themselves, the prescribing of in possession medication, prison doctors being given access to outside telephone calls, examining prisoners with apparent mental health problems, reception processes when a new prisoner whose first language is not English, co-operation and liaison with my investigators and giving consideration to the recommendations made in the clinical review.

## THE INVESTIGATION PROCESS

8. The investigation was opened by a senior investigator on 20 December 2010. She was accompanied by a colleague. The investigator subsequently visited the prison on 25 January 2011 and was provided with some documentation relating to the man. She was later provided with other documents that she requested after her visit to the prison. She also visited the reception and segregation area of the prison and spoke to a number of staff members and a prisoner who came forward. She also discussed the emerging issues with the Governor of HMP Pentonville.

9. Notices were issued informing both staff and prisoners of the investigation. They asked anyone who had any relevant information to contact the investigator. Initially, two prisoners subsequently contacted the investigator. An Assistant Ombudsman and another investigator interviewed them on 17 February 2011. The information given by the prisoners was communicated to the Governor. In June 2011, the investigator returned to the prison to interview a third prisoner after a member of the Independent Monitoring Board contacted her to arrange the interview. She visited Pentonville on 9, 10, 24 March, 13 and 23 April, 24 May and 30 June 2011 to conduct interviews with staff, both independently and jointly with the clinical reviewer. She also contacted another staff member by telephone on 1 June, to carry out an interview, which had been delayed because of shift patterns. She experienced some difficulties arranging interviews.

10. The investigator also contacted a Detective Sergeant (DS) of the Metropolitan Police and shared information with him. A joint meeting was held on 30 June where problems obtaining information were discussed. The DS gave her an unsigned statement from a nurse.

11. The local Primary Care Trust (PCT) was asked to conduct a review of the medical care provided to the man whilst he was in custody. The review and subsequent report was completed by the clinical reviewer. We would like to thank her for her assistance. The final review was received on 7 November 2011.

12. We apologise for the delay with this report. This was caused because of difficulties arranging interviews and obtaining documentation from the prison. The clinical reviewer also experienced delays and problems when interviewing staff. It was further delayed because of the ill health suffered by the investigator.

13. In addition to the clinical review, the investigator obtained a draft internal investigation report into the circumstances surrounding the man's death. This was completed by a nurse practitioner on behalf of healthcare at Pentonville.

14. The investigator wrote to the Coroner's Office to inform them of the investigation and to request a copy of the post mortem and toxicology report. She also spoke to the Coroner's Officers and obtained information relating to the delayed results of the post mortem.

15. One of the Ombudsman's family liaison officers (FLO) spoke with the man's daughter, his nominated next of kin, and explained the role of the

Ombudsman and the purpose of the investigation. The FLO also offered to visit her at home, so that she could raise any concerns about her father's time in custody. The investigator and FLO subsequently visited her and her friend on 22 February.

16. During the visit, the investigator and FLO explained the investigation process in more detail. The man's daughter was keen to know about what had happened about her father's medication and treatment whilst he was in custody. These concerns are dealt with in the body of the report.

17. The man's daughter told the investigator that in Iran her father was a political journalist. She also explained that he had suffered from ischaemic heart disease for some years and in approximately 2005 he had a coronary angioplasty operation at hospital and was being prescribed around 10 types of medication. (A coronary angioplasty is an operation to widen narrowed sections of the heart arteries.)

18. The investigator also contacted an ACCT trainer for the Prison Service, in order to clarify points raised in the ACCT for the man. (ACCT is the process used to monitor and support prisoners assessed as at risk of committing suicide or self-harm. Once placed on an ACCT plan, the prisoner is observed during the day and night at intervals determined by their perceived level of risk. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner within a prison.)

19. The man's family and legal representative received a copy of the draft report as part of the consultation process. Written representations were provided on their behalf in response to the findings of the investigation. His daughter expressed her concern that her father's level of understanding of English was poor. Her father did not always answer questions correctly and this was attributed to his lack of co-operation rather than as a consequence of any language difficulties. The family believe that the language difficulties significantly contributed to the incident before his death and prevented him from communicating his symptoms properly. The man's daughter is concerned that the use of an interpreter was not considered.

20. The family also raised an issue concerning the availability of his GTN spray. This has been covered in recommendation no. 1. They also expressed concerns at how her father was able to access a razor blade while on an ACCT and the way in which his constant supervision was carried out and believe it to have been unsatisfactory. These issues are also subject to recommendations.

21. The investigator has considered all the issues raised by the man's family and has, where appropriate amended the report to reflect their comments. However, some issues raised have been addressed in separate correspondence to their legal representative.

## HMP PENTONVILLE

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

### Healthcare

23. At the time of the man's death a manager headed Pentonville's healthcare department, with two organisations providing health services. A Foundation Trust provides substance misuse and mental health services (including an inpatients' unit) and the local PCT provides psychiatric care and primary care services.

24. The healthcare centre is a 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 dispensing 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 detoxification

25. Pentonville has an integrated drug treatment service (IDTS) on F wing. IDTS aims to increase the volume and quality of the substance misuse treatment available to prisoners, with particular emphasis on early custody, improving the integration between clinical and counselling, advice and through care 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.

### Previous deaths at Pentonville

26. This is the 21st death at Pentonville that this office has investigated since the Ombudsman became responsible for investigating all deaths in prison custody in April 2004. There have been another four deaths since the man died.

### Her Majesty's Chief Inspector of Prisons (HMCIP)

27. The Chief Inspector of Prisons' most recent inspection of Pentonville was in February and March 2011. The report said:

> "Pentonville is an iconic prison, but not always for the right reasons: its four central wings are over a hundred and fifty years old, it has a large and transient population drawn from some of London's poorest boroughs, and its prisoners have amongst the highest incidence of mental ill health and substance abuse of any local prison in the country. Despite these almost insuperable challenges, this unannounced follow-up inspection found that Pentonville was making some progress but inevitably there was much more to do.
>
> Reception remained immensely busy and staff had little time to address all the immediate issues presented by prisoners. Similar pressures on first

night and induction arrangements meant that much work remained to be done to ensure the safety of prisoners in their most vulnerable early days in custody. The atmosphere in the prison was generally calm but violence reduction and anti-bullying systems were weak. Tragically, there had been four apparently self-inflicted deaths since the last inspection and, while some aspects of the care for those at risk of self-harm were good, other areas were underdeveloped.

Many men arriving at Pentonville were dependent on drugs and\or alcohol and treatment arrangements had improved with the introduction of the integrated drug treatment system. There had also been some success, working with the police, to reduce the flow of illicit drugs into the prison. Security was mostly proportionate and use of force was not excessive. The segregation unit was basic but decent.

Staff-prisoner relationships appeared reasonable, but were not supported by an effective personal officer scheme. The environment was generally clean but some accommodation was overcrowded, with unscreened toilets and poor showering facilities. Race issues were well managed but some other areas of diversity, particularly services for foreign nationals, were underdeveloped. Faith provision was comprehensive. There was an impressive health care centre and most services were good."

In the previous report, in 2009 the then Chief Inspector recommended that safer cells should be available on all wings.

**Independent Monitoring Board (IMB)**

28. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are independent of the prison service and the prisons 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.

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

"… the new health service provider, a consortium led by the PCT, 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 able to access all parts of the prison unescorted.] In this report, we also make a recommendation about the filling of healthcare staff vacancies."

## KEY EVENTS

### Police involvement prior to remand

30. The man was arrested on 9 December 2010, for allegedly assaulting two police officers and damaging a police van. He was violent during his arrest. In a risk assessment conducted at a police station after his arrest, a sergeant noted that he "appears intoxicated, an interpreter is required and he needs to be examined by a doctor in respect of fitness to detain".

31. It was recorded that the man had a heart spray, Gliceryl Nitrate, (GTN) in his property. (GTN is a spray that is used under the tongue in case of angina or hear/breathing problems.) In the relevant part of the form, it was noted that he was incapable of signing. A police officer searched him. At 1.13pm, a sergeant authorised continued detention, so that he could be questioned further.

32. The police medical examiner examined the man at 6.56pm on 9 December. He noted that he had "no injuries, had alcohol earlier today, denies any medical conditions, complaining of headache, no visual sx [symptoms], no chest pain, bp [blood pressure]144/79, heartbeat 90 per min, cvs+resp nad [this means his breathing was normal]. PERL {pupils equal and reactive to light].speech coherent.aggressive". He further noted that he was a "standard" risk of self harm at this time and should be subject to CCTV [held in a camera cell) and 30 minute observations. He noted that he was "fit to be detained and fit for interview, transfer and fit for charge. No medical review is required". He was given 2 x 500mg paracetamol tablets for his headache.

33. On 10 December, the man was taken to Magistrates' Court. Part B of the Personal Escort Record (PER, which is completed by all staff responsible for a prisoner which they are under escort) noted that when he was searched by an officer at 9.21am, he became abusive and spat at another officer.

34. He was subsequently remanded into custody at Pentonville. The warrant stated that the "defendant [is] to be referred for psychiatric assessment – hospital wing". This was handwritten at the bottom of the remand warrant.

35. The investigator made enquiries at Pentonville and asked whether the handwritten note on the warrant meant that the man would definitely be detained in the hospital wing at Pentonville. She was told by the Governor that the court cannot tell the prison where they should house a prisoner. He also told the investigator that the inpatients unit at Pentonville was full and that someone with similar issues to those of his would be assessed by the doctor and a decision would be made as to the best place for him to stay whilst he was detained. The investigator has not had sight of the police arrest reports for him, although she has requested them from the police.

### Arrival at Pentonville

36. The man was subsequently taken to Pentonville on remand and arrived at 5.00pm. His PER stated that his risks related to his mental condition, violence, that he offends on bail and conceals weapons. It also stated that he had drug or alcohol issues and was a risk of suicide or self harm. (The

escorting officer passes the PER to the prison reception staff on arrival at prison.)

37. The investigator asked staff about the man's reception. She was told that the procedure was that after arrival, prisoners are checked off a list and given a rub down search. They are then spoken to by the desk officer, who deals with any cash they may have and their personal details are written down and a prison number created. Any cash is taken from the prisoner and signed for it by them. He did not have any cash. The investigator was told that this would be the role of 'officer number seven'. After this, the prisoner is seated in a holding room and subsequently called out by officer number six to go to the biometrics room for the next stage of the process.

**Incident in biometrics room and control and restraint**

38. Officer A told the investigator that he was the 'number six', on 10 December. At 7.45pm, he called the man into the biometrics room. The officer said that, at first, he answered his questions about his name and date of birth. The officer said that the next part of his duty was to go through his property and sort out what he was able to keep and what he was not allowed to keep. He explained that prisoners were not allowed to keep any opened tobacco because there is a risk that there may be drugs in the tobacco. He took his tobacco and his cigarette lighter from him. Both were disposed of in the bin.

39. The officer said that when he told the man that he could not have his tobacco he stopped co-operating and became agitated. The investigator asked whether he understood what he was being told and the officer said that he did. He said that he told him that he would be given a tobacco pack when he went to the wing.

40. The man remained agitated. When the officer asked him to stand at a particular spot to have his photograph taken. he did not respond and then struggled when officers tried to move him to the spot. Eventually, the officer was able to take the photograph and then asked him to come forward to have his fingerprints taken. He remained obstructive and it took some time to complete the fingerprinting process.

41. After this, the officer said he explained to the man that he needed to sign for the property that the prison was keeping in safe storage for him, such as his mobile telephone. The investigator asked if the prison kept a record of property that was discarded but the officer said that the prisoner only signed for property that the prison was keeping in safe storage for the prisoner.

42. At the desk where the man was asked to sign, there is a ball point pen attached to the desk on a piece of string. The officer said that the man subsequently picked up the pen and thrust it towards the officer's stomach area in a stabbing motion. The pen did not make contact with his body because he moved away from it. He said that his colleague then intervened. The investigator was unable to interview this officer because he was on long term compassionate leave. However, the officer made a written record of the incident. In the record, he stated:

> "He [the man] then picked up a pen and threatened the officer with it, then attempted to stab him in the hand with it. I told him to go into the strip booth to get him away from any of the other items that he could try to assault us with or harm himself. He then brought both arms up in the air, clenched his fists and started to bring them down with force."

43. We understand that the incident was taped in the biometrics room, on a closed circuit television camera, although this was requested at the time of the investigation it was not received.

44. Staff shouted for assistance and sounded the general alarm. The man was placed under restraint and handcuffed behind his back, then assisted to walk to the segregation unit for a full search and to move him away from the incident. In interview, the staff who assisted in restraining him said that he was not injured in any way during the restraint and the record states that "he had no complaints".

45. Staff said that they spoke to the man throughout the restraint procedure and explained what would happen and where he was going, whilst he was taken to the segregation unit. The duty governor at that time said that she heard the alarm around 7.45pm and immediately made her way to reception. When she got there, she saw him lying face down on the floor being restrained by officers. The officers then took him to the segregation unit. She oversaw the process and in her interview and subsequent record of the incident she said that he did not sustain any injuries and walked to the segregation unit whilst the officers held him. She said he was handcuffed to the rear.

46. According to the control and restraint policy, once a prisoner arrives in the segregation unit he is handed over to the officers on duty there. The governor explained that this was so that neutral officers who were not involved in the original incident can deal with the prisoner. She said that this often helps to calm the prisoner down.

47. The governor told the investigator that the man only spent a short time in the segregation unit, where he was searched. She said that a senior nurse was present in the segregation unit and he told her that he was not fit to stay there because he thought that he had mental health problems. She said that she immediately arranged for him to be taken to A wing, which is the first night centre at the prison. He was given a single cell because staff felt he might be a risk to others because of his aggressive and unco-operative behaviour and potential mental health problems. In her report on the incident, she wrote that she believed that he had limited English but had previously communicated with staff. She also noted that he told her he wanted a razor blade and also mentioned suicide. She explained that once he was settled on the wing the ACCT assessments would take place.

**Arrival on A wing**

48. A Senior Officer (SO) 1 told the investigator that on 10 December, he was the night orderly officer at Pentonville. The night orderly officer is effectively in charge of the prison overnight and is the person who deals with keeping order. He said that when he came on duty he had been told about the man and the events in reception. As the orderly officer it was his job to see him

and interview him, give him his tobacco pack and telephone PIN number and discuss any particular issues.

49. The SO told the investigator that he went to see the man around 9.00pm. He said that at that time he was “quite ok with me”, but he was concerned about getting some tobacco. Staff said they had given him PIN telephone credit but he said he did not want to make any telephone calls. He said that he would make arrangements for his tobacco.

50. Around 10.30 pm, a nurse assessed the man as part of his healthscreen. The investigator was unable to interview the nurse, although attempts were made to ask her to come for interview by the investigator and the prison healthcare staff. However, the investigator obtained a statement which she made to the police, (unsigned), on 30 June.

51. In this statement, the nurse said that when she assessed him he was accompanied by “at least three prison officers as he had been aggressive on his arrival”. She said that she was with him for around 10 -15 minutes and during her assessment he told her that he had heart disease and that he had previously attempted to kill himself by cutting and, on another occasion, had also jumped in front of a bus. She asked him about his family and he replied aggressively.and was clearly upset about his family situation. She then took his blood pressure, which was normal and said that at the time he did not present any physical health risks. She also noted on the clinical record that he drank alcohol and used cannabis. She completed the clinical record and recommended that he was examined by the doctor because of his heart related issues, his demeanour and his previous attempts to kill himself.

52. At 10.45pm, a doctor examined the man in a small room on the wing. The SO was present during the assessment because of the previous assault on staff. The doctor said that during her assessment of him, he was very loud and aggressive and was making large body movements, did not always co-operate with her questions and swore a lot. She said it was very difficult to obtain information from him. At the healthscreen he told her that he would kill himself “by tomorrow” and said that he was looking for something sharp to use to cut himself. She said that at this time he was angry and using aggressive language and swearing aggressively about his family situation, the prison officers and healthcare staff. He told her that he had previously been on hunger strike for 20 days, although it is not clear when this was. The investigator asked if she felt that he could understand English and she said that he was speaking in English and could understand her questions, although he chose not to answer on occasions.

53. During the healthscreen, the doctor found that the man had heart surgery, (percutaneous balloon coronary angioplasty in 2005 at hospital) and he told her that he was currently prescribed around ten types of medication. However, he could not remember them all. She also commented on his mental health. She said that based on what she heard about the incident in reception and on her assessment he needed to be referred for a mental health assessment. She said that the mental health team did not work at weekends so, although she made an urgent referral, it would not have been dealt with until the Monday morning.

54. The clinical reviewer asked the doctor how she would normally find out what somebody like the man was being prescribed. The doctor explained that it was a problem, especially when a prisoner came in on a Friday night, or over the weekend. She said that on some occasions she had asked an officer to contact a family member over the telephone; however she said that it was not encouraged because of patient confidentiality. Also, she said that in this particular instance he was swearing about his family, so it might not have been appropriate to contact them.

55. She also said that making further enquiries regarding a prisoner's medication was difficult for her even during the week. As she had not been given a PIN for the prison telephones, she had to ask someone else to make the telephone call as she could not make a call outside of the prison.

56. The man told her that he had previously tried to kill himself but would not say when or why. He also said that he heard voices in his head telling him to kill himself and had felt like that for around seven years. She was concerned for his wellbeing and subsequently completed the concern and keep safe form, which starts off the ACCT process. She said that she had received basic training in ACCT procedures and knew how to open an ACCT but she was not trained to make decisions on how often observations should be carried out.

57. However, on this occasion, she felt that the man should have a constant supervision until he settled down on the wing. She was not involved in the rest of the ACCT process after completing the concern and keep safe form. She passed this to the wing officer.

58. At the conclusion of her assessment, she prescribed him aspirin (a pain killer which can also thin the blood) and simvastatin (a statin used to control cholesterol) tablets for his heart, zopiclone tablets to help him sleep and reduce his anxiety and a GTN spray for his heart. She noted on the prescription that he should have the GTN spray in his possession but that he should attend healthcare to receive the other medication. After the examination, the SO took him back to his cell. The clinical reviewer noted in her clinical review that he had been in police custody for a number of hours prior to his detention at Pentonville.

**ACCT**

59. After the SO had taken the man back to his cell, he then went to speak to the doctor again regarding the ACCT. In interview, the SO said that she had told him that she was thinking that he should be on a constant supervision for a couple of hours because she was concerned about the initial period when he was returned to his cell and the cell door being closed. She said she had given him a sleeping tablet, so he should settle down quickly. She asked if a nurse needed to be brought in to carry out the constant supervision but he said not if it was just for a couple of hours and that he would arrange one of the operational support grade staff to cover it.

60. The investigator asked if there was a safer cell or a gated cell available and if the man could have been moved to that. The SO said that there were no gated cells in the prison except for one in healthcare. He explained that whoever was conducting the constant supervision would sit on a high chair

and look through the cell observation panel (a vertical hatch) and there would be a night light on in the cell.

61. The SO and an officer subsequently completed the next part of the ACCT documentation, which is the immediate action plan. The SO is a trained ACCT assessor and the officer has completed the basic ACCT training. The following shows a table extract from the ACCT document:

| Immediate action required | Action | By whom | Completed | |
|---|---|---|---|---|
| LOCATION | Located in single cell due to mental health concerns | Wing staff | Yes | |
| Frequency of support | Constant watch for first 2 hours Half hourly obs after for first night | Wing staff | Yes | |
| Phone access | Given charged PIN but does not want to speak to anyone | ? staff | Yes | |
| Listener access | Full access offered but states he does not want to speak to them | Night Orderly Officer | Yes | |
| Other immediate actions | Doctor has referred to MHIT. This is a matter of urgency | Doctor | Yes | |

62. The SO said that he had assessed the risk of the man sharing a cell with someone else but they had decided that it was safest for him to be in a single cell because of his aggressive manner.

63. The constant supervision log in the ACCT document starts at 11.15pm and shows regular checks were recorded every 15 minutes by two officers. At 1.07am, the record states that the observations change to half hourly. No review is shown in the record and when the investigator asked the SO if there had been a review after two hours he said “I didn’t actually see him then; I asked staff if there had been any problems, no, he’s been quiet”. The constant log indicates that he appeared to be asleep from 12.15am until 8.50am.

64. At 8.45 am on 11 December, Officer B went to the man's cell to complete the next part of the ACCT process. The officer said that he was just waking up when he went to his cell. He said he was just groggy from waking up and he was not aggressive or angry. He subsequently took him to a private office and explained the ACCT process to him, so that he knew what was happening and why. The officer said that he was able to understand him and he understood English. He said that he knew this because he asked him for razors and he said that he could not have any at that time because of the risk he posed to himself and others. He said that he understood what this meant and said that he would look for something else then.

65. When the officer asked the man what his problems were, he replied that it was the Home Office and life in general but he did not want to talk about it further. Throughout the interview, he seemed angry. He started to raise his voice and wave his arms around and swore a lot. He also repeatedly told the officer that he had been looking round his cell for something to harm himself with and he wanted to kill himself. The officer said that he believed he was not taking the interview seriously because at a number of points when he asked him about self harm he did not answer but smiled and grinned at him.

66. One of the questions in this interview was about 'reasons for living and coping resources'. The man explained to the officer that his wife and son were still in Iran and he had not seen them for seven years. He said that he cared for them and loved them and had a good relationship with them but if he died it would not matter. He also told the officer that his daughter was living in this country and he needed her telephone number and that of his solicitor from the directory in his mobile telephone.

67. The investigator asked how this could be arranged. The officer explained that, because it was the weekend it would not be possible as the property would have been put away into the valuables storage. The man would have to put an application in, or speak to one of the landing officers on the Monday morning, to ask for the numbers to be obtained from his telephone. The interview concluded by the officer writing that the man needed a mental health assessment. The investigator asked if this assessment was normally completed by one officer alone and he replied that it was, because "you can maybe get people to open up a bit more if it's just one on one".

68. After this interview, SO 2 also interviewed the man for the next part of the ACCT process. He explained that this part was the action after the initial interview and it was when a caremap was completed. (A caremap describes the steps and decision points in the management of the ACCT.) The SO told the investigator that he was an advanced trained ACCT assessor, which was a voluntary role on top of his normal management duties.

69. The SO said that his first thoughts about the man were that he was depressed and angry because he was saying he wanted to kill himself. He said that he was agitated initially, saying "there's nothing we can do, it's the system". However, after a while he calmed down and seemed to be feeling better.

70. During the interview, the man told the SO that he was frustrated and angry with the Home Office because he had been trying to bring his wife and son to the United Kingdom from Iran. He said that originally he did not want to return

to Iran but because he was unable to see his family for so long he now wanted to return but was unable to do so because of passport issues. He also told the SO that if he had not been arrested he would have set himself on fire outside Parliament because he was so frustrated with the situation. The SO made a note on the caremap for him to have an interview with the immigration officer who was attached to the prison, but as the immigration officer only worked on weekdays it would have to wait until Monday morning.

71. The investigator asked the SO if the man understood everything that was being said to him. He said that whilst there were some problems in his use of verbal expressions he did feel that he understood what was being said. He also apologised for his behaviour at reception and said that it was maybe because of the language barrier that he did not understand why the officers were taking his tobacco off him. He said that he thought they were trying to "wind him up" when they showed him his tobacco and threw it in the bin.

72. The SO said that he spent around 45 minutes with the man and they agreed three objectives for the action plan. These were: to resolve his immigration issues, stabilise his mental health and for him to get involved in constructive activities whilst he was in prison. The SO noted on the ACCT that he should subsequently be subject to hourly checks during the day and that there should be a formal review on 18 December.

73. At the end of the interview, the man was calmer and livelier and made himself a cup of tea on the wing. The SO said that during the rest of the day he came to him with every problem that he had and he believed he had struck up a rapport with him.

74. Later that day, a nurse carried out a second health screen with the man. She told the investigator that she was a charge nurse and was both general and mental health qualified. She said that when he came into the room, he was aggressive and said he did not want to be in prison. The investigator asked if the nurse felt threatened by his attitude. She said that she did the assessment with him on her own and, although he was angry, she did not feel that it was aimed at her and therefore did not feel threatened.

75. The nurse was aware that the man was on an ACCT. The purpose of her assessment was to look at his prescriptions, how he should have his medication (whether he should keep it himself, known as "in possession", or whether he should have to go to healthcare to be given it) and ask other questions about substance misuse and general health issues according to the "well man" assessment.

76. In the clinical record, the nurse noted that the man was not suitable to have his medication in possession because of the risk that he might take an overdose. In interview, she said that he could not have his medication at that stage anyway because the prescription that the doctor made the previous night would not have gone to the pharmacy until Monday. However, it is clear from the records that he received some medication over the weekend because there were times when staff encouraged him to take it. (This is discussed further later in this report.) When the investigator asked about his GTN spray, the nurse said she had not seen the prescriptions and she was not aware that he did not have the GTN spray in his possession.

77. The nurse noted on the clinical record that the man was a very heavy drinker and was suffering from chronic alcoholism. This was the first time any note of alcohol dependency had been addressed with him. When asked about medication or treatment for possible withdrawal symptoms, she said that it would be the doctor who prescribed any medication. In interview she could not remember what he said about his alcohol intake but she noted in the clinical records that it was above nine units per day. There was no referral made for him to see a doctor about withdrawal symptoms or for an assessment of any alcohol related issues.

78. The ACCT observations continued at hourly intervals during the rest of 11 December. There is nothing of note in the record for the rest of the day and night. SO 2 said that the man spent time out of his cell during the afternoon but he did not associate with other prisoners.

79. Around 10.00am on 12 December, the man was out of his cell on association when the nurse saw him walking towards his cell with blood on his clothes. She noticed an officer and another nurse following him. It has not been possible for the investigator to find out who the officer or the other nurse were. The incident report, signed by an officer, states that the man, who had cut himself, was walking down the landing. It states he was in possession of a razor blade and "was escorted back to his cell where he tried to barricade his door." In interview, the officer said that he only dealt with him in the afternoon of 12 December and was not aware of the self harm incident.

80. An Orderly Officer (OO) told the investigator that the officer had said that the man had cut himself and was in his cell. He was being quite difficult and still had a razor blade. The nurse said that when he got to his cell he closed the door on everyone and took the blade with him. She said he was shouting "I don't want anything from you", repeatedly.

81. SO 2, an officer and the Orderly Officer (OO) told the investigator that they were at the man's cell door. After returning to the cell, he made a barricade of furniture against the door. The officer said that the barricade was made with a chair and when he looked through the cell observation panel he saw him with blood on him, holding the razor to his throat as if threatening to cut himself.

82. The officers and the nurse continued to talk to him through the cell observation panel and then managed to push open the door and enter the cell. The OO went into the cell and talked to him and eventually he calmed down and put the razor down. The investigator asked what the razor looked like and he said that it was a small razor which had been taken from a Bic razor that prisoners use in the prison. It was not clear how he had got the razor but the officer said that he could have got it from another prisoner, an officer who did not know the situation or possibly from a bin.

83. Staff subsequently removed the piece of furniture that the man had used to barricade the door, and any sharp objects, from the cell. The nurse continued to talk to him to encourage him to let her treat his cuts. She said that although there was a lot of blood, the wounds were superficial and because he was wearing white clothing it looked much worse than it was. He continued to refuse treatment or a change of clothes. She thought that the cuts were not

life threatening, but spoke to the duty governor. They agreed that the ACCT should be reviewed and the observations on him should be increased to constant.

84. The investigator asked the duty governor why there had not been a full review of the ACCT and why the increased observations had not been written on the front page of the ACCT document or in the constant log. She replied "It should be logged on the front when the observations are increasing, it doesn't appear to have been". There was a record of the incident in the constant log of the ACCT document but not the increased observations.

85. Staff told the investigator that constant observations are arranged by healthcare, through a nursing agency. The constant log notes a number of entries during the afternoon of 12 December, all at 15 minute intervals, although it is not clear who the observer was because the signature is illegible. During the afternoon, the man refused to go out for exercise and spent some time praying on his bed. At 4.15pm, the constant log notes that someone gave him his adjudication sheets from the incident in reception. (When a prisoner is charged with an offence an adjudication sets out brief details of the alleged incident and the relevant prison rule that has been breached and when the case will be heard.) (From the signature on the log it is most likely to have been an officer.) According to the ongoing log, he said that he did not understand what they were, nor did he engage in conversation with the officer.

86. At 4.45pm, the man asked the constant supervision nurse for some more tobacco but was refused. Staff said that he did not have any more left. At this, he became angry and banged his cell door. However, it is noted that someone gave him a cigarette at 5.15pm. Shortly after this it is noted that he went to sleep and according to the log he slept for the rest of the night. The signature on the constant log changed at 8.15pm, which indicates a staff change to the night time constant supervision nurse. The signature of the night time observer is illegible. Healthcare managers told the investigator that this duty was performed by a Health Care assistant (HCA), an agency worker.

87. It has not been possible for the investigator or the clinical reviewer to interview the HCA because staff at Pentonville could not give her personal details to them. Extensive enquiries were made at the agency where she worked and they too could not give personal details of their staff. The investigator asked if the agency would pass on a message to ask her to contact the Ombudsman's office and speak to her. She also wrote a letter to this effect, but there has been no subsequent contact.

88. At 6.00am on 13 December, the HCA noted on the log that the man was awake but in bed. At 6.30am she noted, "Awake complain of heart pain." There is no note of any action that she took in respect of the pain. The cell bell sheet indicates that the cell bell was pressed at 6.37am and was reset three seconds later. The cell bell was pressed again at 6.43am and reset seven seconds later, again at 6.48am and reset six seconds later, and again at 6.50am and reset 12 seconds later. The constant log notes that at 6.45am, the man:

"complain[s] of heart attack, officer informed and Oscar 1. [Oscar 1 is the officer in charge of the prison overnight.] I came around, the inmate is sounding on everyone and refuse treatment with nurse."

89. As it has not been possible to interview the HCA, it has been difficult to actually piece together the time frame of what occurred during the beginning of this incident. However, the investigator spoke to a number of officers who were on duty that morning and has used the police statement of the nurse who attended to the man.

90. A nurse said in her statement to the police that, around 6.50am, she was asked by a female landing officer to attend the man's cell because he was complaining of heart pain. She said that when she arrived which was seconds later, she had to wait a couple of minutes for Oscar 1 to bring the keys to open the cell door.

91. SO 1, who was Oscar 1, was on another wing when he received a radio call to attend the man's cell. He told the investigator that he went to A wing, opened the cell door and saw him walking about. He asked what the problem was and he banged his chest and said "heart". The SO asked if he had problems with his heart and at that stage he started to raise his voice and became aggressive. The SO said that he told him that he had a nurse with him who would examine him. He also said that his clothes were bloodstained. He said the nurse then said "can you give him a new top?" The SO asked a member of staff to get a new t shirt for the man. He then told him that if he put the new t shirt on he would take him to healthcare for treatment.

92. Immediately, the man started swearing at the nurse and became very aggressive. The SO said the nurse said "I'm not going to see him while he's like this." He remained angry for about ten minutes, with the SO telling him to calm down. The SO described him as "very angry, really, really screaming at me, really." He said that the nurse repeated that she was not going to examine him at that time and then she left. He told him that he needed to calm down and that he could not see the nurse whilst he was being so aggressive. He then shut the cell door. He subsequently asked the constant supervision nurse and an officer to keep an eye on him and let him know what happened.

93. The incident is described slightly differently in the nurse's statement to the police. She stated that, when she entered the cell, the man was standing up. She noted that his clothes were covered in blood from the previous day. He was complaining of heart pain. She said that she wanted to check his blood pressure and carry out an ECG (electrocardiogram, a test which measures the electrical output in the heart) but this was not possible because he was being aggressive and swearing at her and she could not get close enough to provide any treatment. She asked him how long he had the pain and if it was radiating anywhere else but he was unco-operative. She also offered him a change of clothes because his were covered in blood. He responded by saying "You can fuck off, I don't need a change of clothes, I'm having a bloody heart attack".

94. She said that it seemed that then the man was "going to get physical" so an officer had to step in between them. She said that he continued to refuse any

treatment and as she assessed that he had no obvious signs of having a heart attack, such as sweating, and he was breathing properly, she left the cell for her own personal safety. She told him that when he had calmed down she would come back back. He replied “Fuck off”.

95. She stated that in her opinion “the situation did not present a critical issue and there was no reason to call an ambulance or send him straight to hospital”. She returned to the office and completed her notes asking for a doctor to see the man later that morning. She then went off duty. As noted before my investigator has been unable to interview this nurse.

96. After staff had left the cell, the man continued to shout and swear and bang the cell door for about another ten minutes after it was shut. He then settled down and had a cigarette. The HCA noted in the log that at 7.00am, “after he has shout and scream, he then lying on his back and fall asleep”. She made two more entries at 7.15am and 7.30am saying he was asleep on his back.

97. In interview, the clinical reviewer asked the interim Head of Healthcare how someone can assess whether a prisoner is sleeping or has collapsed when they are looking through the cell observation panel, especially at night when the light is low. She replied, “A question I have asked on many occasions”. She explained that the nurse has a pin torch and other staff said that there was a night light left on in the cell when someone was on an ACCT. However, she also said that she did not think that was satisfactory.

98. Around 7.30am, there is a shift change and new staff come on duty. The new staff take part in a briefing which normally starts at 7.30am and lasts around 10 to 15 minutes. The SO passed on the information about the man to two officers.

99. SO 3 also came on duty at 7.30am. After the briefing she was walking to B wing when the HCA asked if someone could supervise the man whilst she went to get some hot water. The SO said that she would take over and the HCA went to B wing to get the water. She looked into his cell through the cell observation panel. She told the investigator that the lights were fully on at this time. She noticed his clothing was blood stained but realised it was not fresh. She saw him lying on his back with one arm and one leg just hanging over the side of his bed. She looked for movement of his chest but could not see any at all. She then called for another officer to assist her.

100. An officer who was close by went to the cell. The SO opened the cell door and called the man’s name twice but got no response. She subsequently went over to the bed and noticed his eyes were slightly open. She felt for a pulse and noticed that he felt very hot. She could not find a pulse so she immediately asked the officer to call a level 1 emergency code over the radio, which he did. (A level 1 emergency code is used where there is a life threatening incident.)

101. The SO told the investigator that there was a treatment hatch opposite the cell where there were a lot of healthcare staff who were coming on duty. Two nurses immediately responded. It took them seconds to get to the cell. The SO told him what had happened and Nurse A checked for a pulse in his neck and could not find one. Nurse B remembers it slightly differently. In interview,

she said that she checked the man's pulse and asked Nurse A to help her to move him onto the floor. She said that his body felt warm at that stage. They immediately pulled him onto the floor onto a hard surface and started cardio pulmonary resuscitation (CPR).

102. Other healthcare staff arrived, along with an officer. The SO noted in her report of the incident that the constant supervision nurse returned and witnessed the ongoing activities. The defibrillator (a machine which uses electricity in the right circumstances to re-establish a regular heartbeat) and an ambu bag (which is used to administer oxygen) were attached to the man at 7.45am, according to the log of the incident. Nurse A, the officer and other staff took it in turns to do compressions until 8.10am, when the paramedics took over. The man was pronounced dead at 8.18am by paramedics.

103. The Governor at Pentonville held a hot debrief shortly after the man was pronounced dead. (A hot debrief enables staff to come together to discuss what happened and the emergency response. It is also to offer support to those involved in the incident.) The investigator has not seen the minutes of the meeting but she asked the staff that she interviewed if they had been invited. Most said that they had and they had been offered care from the duty care team. Prisoners subject to suicide and self harm procedures were subsequently reviewed.

104. A prison governor said that he was the only trained family liaison officer (FLO) at Pentonville and he was assisted by an officer. The governor said that he made some telephone calls to ascertain the man's next of kin and subsequently visited his daughter personally to break the news. Following this, the officer liaised with her. The Governor agreed to cover the funeral expenses.

**Information received after the man's death**

105. Two prisoners contacted the investigator in response to the notices of the investigation. Both were interviewed by another investigator and an Assistant Ombudsman. Both were worried about reprisals from prison staff. The investigator subsequently told the Governor about the information that they contributed in order to safeguard them.

106. Prisoner A was living in a cell close to the man over the weekend of 10 -13 December. He told the investigators that he heard shouting on the night of 12 December but did not know if that was normal because it was his first time in prison. He said that he fell asleep around 11.00pm and woke on occasions through the night. He then woke up and heard a lot of banging and shouting from his cell. He heard phrases such as "come over here" and then he heard "help me" and heard the cell bell being pressed. He heard officers going past the man's cell and then in the early hours of the morning he heard an officer say to him, "What do you want?" He heard the man reply "I'm having a fucking heart attack". The officer replied, "You're not having a heart attack, my nan had a heart attack and didn't swear". He said he then heard officers chuckling but then went back to sleep.

107. The prisoner also commented on the constant supervision, saying "he couldn't have been on constant supervision because he kept pressing the bell". He

said that he had since seen prisoners on a constant supervision and noted that that there was a difference because officers conducting the constant supervision would talk to the individual being watched.

108. Prisoner B said that he was woken by banging in the night/morning. He said that he heard someone shouting that they were having a heart attack and then heard someone shouting loudly “Shut up” and that another officer responded saying that he wasn’t having a heart attack.

109. In June the investigator was contacted by a member of the IMB who had received information from another prisoner who wanted to contribute to the investigation. The investigator subsequently visited him at Pentonville on 30 June. The prisoner had been on the wing at the time of the man’s death and said that after his death he made a complaint to the governor acting as FLO about what had happened. He said that the governor had spoken to him and said that it would be investigated by the Ombudsman’s office. The investigator has not had sight of any written complaint nor any response. The prisoner was subsequently released and it seems that his complaint was not recorded. He had recently been remanded back into Pentonville and this had reminded him of the death of the man. As he felt that nothing had been done, he decided to contact the Ombudsman’s office through the IMB.

110. The prisoner told the investigator that around 6.00am on the morning of the man’s death, he was woken by him shouting for help. He said he was repeating over and over, “help, help, heart attack, heart attack” and was banging about in his cell. He said this carried on for about an hour. He knew this because his television had the time on it. He said the man pressed his cell bell lots of times during this period and officers came to his cell about “twenty times”. He then heard an officer saying “You’re not having a heart attack; you wouldn’t be able to shout if you were having a heart attack”. He said that he heard officers slam the observation hatch shut each time he called for help and then heard them walk away. The investigator asked if he could see a constant supervision nurse at the cell door but he said he that he could not.

## ISSUES

### Physical and mental health

111. Healthcare staff who examined the man on his first night at the prison experienced difficulties finding out what medication he should be prescribed. After he told staff that he had heart disease, he was prescribed a GTN spray to keep in his possession and medication for high blood pressure and heart problems. A doctor said that generally she tried to get information on a prisoner's prescriptions from their GPs during the weekdays, or their pharmacists. However, she said that she could not make telephone calls out of the prison because she had not been issued with a PIN number, which is necessary to make outside calls.

112. The clinical reviewer said that the physical history which was taken at the healthscreening was appropriate. She said that the doctor prescribed appropriate medication based on the limited information that she had at that time. However, she noted that the man was not provided with his GTN spray, which he should have been given to keep in his possession.

113. Interviews with healthcare staff indicated that there was a general misunderstanding and ambiguity about who should have given the man his GTN spray. The clinical reviewer makes two recommendation regarding the in possession medication and the PIN phone numbers for GPs working in the prison. We subsequently make the following recommendations.

**The Governor and Head of Healthcare should ensure a patient who requires "in possession medication" is given it as soon as possible after their reception.**

**The Governor and Head of Healthcare should ensure the expeditious issuing of PIN numbers to healthcare staff so that they can make enquiries about prescriptions, and other health related matters, outside the prison.**

114. Staff repeatedly told the investigator that when the man entered Pentonville, he presented with "bizarre behaviour". He was described as aggressive, loud, swearing, making large arm movements and had an unkempt appearance. Many staff said that they believed that he had some form of mental illness. Indeed, the warrant from court asked that he go to the hospital wing when he was remanded into custody.

115. Although he was referred for an urgent mental health assessment, the relevant staff were not available over the weekend to make such an assessment. He therefore had to wait until Monday before any assessment of his mental health could take place. There were no beds available in healthcare and the doctor said that in her opinion he did not need to go to healthcare from a medical perspective. She believed that the ACCT would provide the observation and support that he needed at that time. She said that if he had needed hospital treatment she would be able to make that decision and did not feel it appropriate on her examination of him.

116. The clinical reviewer commented in an email to the investigator, dated 19 September 2011, that in the community it would be normal for a patient to have a delay of longer than 72 hours for an urgent mental health review as an outpatient, if requested by a GP. However, she states that the GP could send a patient to the Accident and Emergency Department at hospital for an urgent assessment. The prison doctor stated that she did not think that this was necessary with the man. However, she concludes that in her opinion, access to the mental health team in Pentonville is faster than would be expected in the community. She also pointed out that in prison there was the potential for regular reviews or a constant supervision under the ACCT procedures.

**ACCT procedures on 10 December**

117. When the doctor examined the man he told her that he wanted to kill himself. He made it very clear to all healthcare staff that he was looking for a way to harm himself and wanted razor blades. She subsequently completed a concern and keep safe form, to start the ACCT procedure. She said that she had basic training in ACCT but was never involved in reviews or setting the extent of observations.

118. The doctor subsequently discussed the ACCT with SO 1 and it was agreed that the man would be on constant supervision for two hours, then reviewed, and if appropriate reduced to half hourly observations. He was given a single cell on the first night centre on A wing. The reason he was given a single cell was because of the risks he posed to others at that time. There were no gated cells available and staff said that there was only one, which was located in healthcare.

119. Staff said that a constant supervision was carried out by an officer or, if it is was for a long period, an agency nurse, arranged through healthcare. They said that throughout the night the observer sat on a high chair looking through the cell observation panel of the cell door and during the dark periods a night light was kept on so that the observer could see the prisoner. The Interim Head of the Primary Care team at Pentonville said that she did not think this was a satisfactory situation because the observer would find it difficult to see exactly what the prisoner was doing or whether they were breathing.

120. During the first two hours the man was observed by two officers and as he seemed to be settled after two hours the observations were reduced to half hourly. There is no note of a face to face review taking place and SO 1 said that he asked staff on the wing how he was over the telephone and was told that he had settled down. The constant supervision was then changed to half hourly observations.

121. Prison Service Order (PSO) 2700 4.2.1, states,

> "Constant observation can only be authorised by a doctor or nurse (in consultation with the Duty Governor)….Constant observation is where the prisoner is observed by a designated member of staff who remains constantly in his or her presence.
>
> "Prisoners placed under constant observation should be urgently referred for mental health assessment. Their case must be reviewed as soon as is

practicable, and certainly within 4 hours……and every four hours for thereafter for the remainder of that establishments core working day."

122. The SO explained that although he arranged for constant observation for two hours, it was not an official constant supervision. He said that he had agreed to half hourly observations but had decided (because of the doctor's concern) to have constant observations for the first two hours. We therefore accept that the constant supervision observation at this time provided added protection for the man and make no recommendations in respect of the requirements in PSO 2700 above. However, we make two recommendations relating to gated cells (which was also a recommendation made by HM Inspectorate of Prisons in 2009) and face to face multi disciplinary reviews in ACCT reviews.

**The Governor and Head of Healthcare should ensure that a gated cell is available on each wing and, in particular, on the first night centre.**

**The Governor should ensure that ACCT reviews are conducted face to face and as a multi disciplinary function, embracing the expertise of specialist staff such as the healthcare team, chaplaincy and others.**

**Alcohol withdrawal**

123. During the man's second healthscreen with a nurse, he told her that he drank over nine units of alcohol per day. She noted in the medical records that he had "chronic alcoholism". However, when the doctor examined him the night previously she did not notice any signs or symptoms of alcohol withdrawal.

124. The clinical reviewer comments in her review that a full history of drug and alcohol use was obtained from the man. He was not referred to drug and alcohol services because this was not relevant. In her opinion, he received care which met his needs. We are satisfied that this is not an issue and make no recommendations in this regard.

**12 December – self harm incident**

125. The nurse saw the man walking along the prison landing with blood on his clothes. At this stage, he was subject to hourly checks according to the ACCT. She noticed that he was being followed by an officer. It has not been possible to find out who this officer was but some staff thought it to be a particular officer. However, at interview, the officer said that he was only involved with him on the afternoon of 12 December when he invited him out for exercise and then later when he helped the nurse to encourage him to take his medication.

126. When the man got to his cell he was able to barricade himself in with a razor blade still in his possession. No one could explain how he had obtained a razor blade, particularly when he was on an ACCT. However, SO 2 explained that he could have got it from another prisoner, or possibly an officer who did not know the circumstances or from a bin. In addition a prisoner, who was a cleaner at the prison, told the investigator that cleaners generally gave prisoners razors. Although this is anecdotal, we are concerned that if this is the case anybody who is on an ACCT may have access to razors.

127. Although it is not clear how the man obtained the razor, we are concerned about the explanations given to the investigator and the risk to staff, other prisoners and he himself. We therefore make three recommendations regarding the dispensing of razors.

**The Head of Healthcare and the Governor should ensure that all razors are issued and disposed of safely, by a prison officer or member of the healthcare team only.**

**The Head of Healthcare and the Governor should ensure that if a prisoner is on an ACCT, they should only be given a razor by an officer, should be supervised whilst using the razor and the razor immediately returned to the officer.**

**Treatment for cuts after self harm incident 12 December**

128. After the man had given up the razor to staff, he refused to be treated and did not want a change of clothes, although they were offered. As the nurse on duty was able to make an assessment that the cuts were superficial and not life threatening, we agree that little more could be done by healthcare at this stage.

129. The duty governor, an officer and SO 2 completed a self harm incident form outlining the incident. It is noted that, because the man was still making threats to kill himself, his supervision on the ACCT should be increased to constant.

130. The ACCT ongoing log mentions that the man had cut himself and refused treatment. However, there is no evidence of a full ACCT review taking place with him, nor does the log note the increased observations. There is no note on the ACCT document to state how many meaningful conversations should take place and during the afternoon and evening of 12 December no conversations were recorded.

**The Governor should ensure that all ACCT documentation is fully up to date, with reviews taking place according to PSO 2700, and clear recording of how many conversations should take place and recording of these in the ongoing log.**

**Events leading up to the man's death**

131. The ongoing log states that the man was asleep from 5.45pm until 6.00am. At 6.00am, it is recorded that he was awake lying on his back. At 6.30am, the HCA has written "Awake complain heart pain". There is no record to say what the HCA did at this stage, but at 6.45am she made another entry saying that she informed an officer. It can only be assumed that this is when the nurse is called to his cell.

132. The man became violent and abusive and refused treatment. The nurse assessed that he did not seem to have symptoms of a heart attack and therefore she did not treat him. After the nurse left the cell, at 7,00am, the HCA noted on the ongoing log that he then lay on his back and fell asleep.

133. As noted earlier because of the lack of information from both healthcare staff involved, it has been very difficult for the investigator to get a clear timeline of the events at this stage. The clinical reviewer commented,

> "The nurse who attended when the prisoner complained of chest pain did not take steps to respond to his symptoms. This is not care according to National Service Frameworks.
>
> "The Health Care Assistant performing the constant supervision did not take the prisoner's cardiac history into account when, following complaints of chest pain, the prisoner lay on his back without movement."

134. The clinical reviewer states that the above actions fall below the level that a patient would normally expect to receive in the community and that they were "not reasonable or appropriate". She states,

> "There were delays due to nursing staff not recognising that a cardiac arrest had occurred … with the benefit of hindsight it is clear that the prisoner was describing angina and then a heart attack, which was confirmed by the post mortem. The focus of the care of the prisoner was directed towards the perceived risk of suicide, by the use of the ACCT document and constant supervision. The physical needs of mental health patients are often overlooked in the community and there are currently attempts to encourage physical health checks in the community using Quality and Outcomes Framework (QOF). There are however, difficulties with consent. In this situation the prisoner had refused care after cutting himself and the nurse on duty during the incident was 'unable to do observations'".

135. The clinical reviewer makes two recommendations. We make the following recommendations based on her clinical observations.

> **The Head of Healthcare should ensure that healthcare staff use basic principles to identify risk of physical health in patients with mental health conditions. If nursing staff are fearful of examining a prisoner in this situation they should involve discipline staff and contact senior healthcare managers for support and advice.**
>
> **The Head of Healthcare should ensure that staff are aware that a prisoner who is complaining of chest pain requires access to GTN spray if prescribed, an ECG and observations, and emergency referral to hospital if angina is suspected.**

136. The HCA made two more entries in the ongoing log stating that the man appeared asleep on his back. These entries were made at 7.15am and 7.30am. Around 7.45am, she asked SO 3 if she could supervise him whilst she went to get some hot water.

137. The SO took over and when she looked into the cell she could not see him breathing. She shouted for another officer and subsequently opened the cell door and found him unresponsive. An emergency level 1 call was put out

over the radio and two nurses were quick to respond as they were only a few feet away from the cell.

138. Cardio pulmonary resuscitation (CPR) was commenced immediately as the man was not breathing and staff could not find a pulse. He was appropriately moved onto a hard surface, a defibrillator and an ambu bag was attached to his body and an ambulance was called. Officers and healthcare staff took it in turns to carry out chest compressions until paramedics arrived. He was pronounced dead at 8.18am.

139. The clinical reviewer commented on the subsequent supervision of the man after he had told staff that he was having a heart attack. She said,

> "Certain medical conditions, such as low blood sugar (hypoglycaemia) and epilepsy may lead to apparently bizarre, aggressive and uncontrolled physical movements. Clinical and nursing staff have been trained to recognise the associated symptoms and signs such as sweating, pale skin and variation in level of consciousness. Angina is usually associated with sweating and pale skin. The practicality of assessing this through a small vertical hatch is limited. It is a priority that healthcare staff feel safe when treating patients with a history of violence. In the community patients may have special notes, for example that the police need to be in attendance when making a home visit for the safety of the healthcare staff. In prison the availability of discipline staff to fulfil this role should ensure that all prisoners can be assessed and treated during medical emergencies.
>
> "There needs to be a nationally agreed minimum level of movement eg signs of breathing or movement of limbs to state that a prisoner is asleep. Additionally the use of technology eg movement alarms could be used. These need to be cascaded to all staff undertaking a constant supervision. If these signs cannot be seen the cell door needs to be opened to confirm that the prisoner is well."

140. The response to the SO's emergency call seems appropriate. The clinical reviewer comments that there was "excellent teamwork in attempted resuscitation, equipment readily available and nurses able to attend swiftly to the incident". We concur with her view in relation to the emergency response but would draw attention to the clinical reviewer's comments above in respect of constant supervision in a cell which is not gated.

**Miscellaneous issues**

**Incident in reception/ language barrier**

141. The investigator made enquiries with most staff about the man's understanding of the English language. Whilst it seems he might not have been fluent in English the majority of staff said that he could understand them and was able to respond to questions put to him. SO 2 said that when he interviewed him for the ACCT assessment, he told him that he had misunderstood what the officers in reception were doing with his tobacco and thought they were trying to "wind him up", when they disposed of it in the bin. It may have been that the actions of the officers in reception increased his agitation and this could have been a precursor to the aggression he

demonstrated over the weekend. We make a recommendation to help ensure that there are fewer misunderstandings of this nature in future:

**The Governor should ensure that staff in reception explain procedures carefully and slowly to prisoners, especially when English is not their first language, using interpretation when necessary, and clarify that the prisoner understands.**

**Problems arranging interviews**

142. Both the investigator and the clinical reviewer experienced delays of up to an hour waiting at the gate to interview staff. Furthermore, there were problems arranging for staff to attend interviews on the numerous dates given by the investigator. Although the Head of Healthcare sent a letter to a nurse to ask her to contact the investigator, the nurse had by then resigned from her post. Although the investigator made subsequent requests by letter and telephone the nurse did not attend for interview.

143. In respect of the agency healthcare assistant, prison healthcare staff said that they had asked the agency for the HCA's details but the agency could not provide them because of data confidentiality. Both the prison and the investigator contacted the agency to ask if they would pass a message to the HCA, but she did not make contact and was therefore unable to be interviewed.

144. PSO 2710 "Follow-up to deaths in custody" contains mandatory instructions for Governors/Directors of Contracted Prisons, who remain responsible for:

- Taking immediate action on discovery of an apparent death.
- Notifying next-of-kin and providing support for the family. **This remains a crucial role for the Prison Service.**
- Providing support for staff and prisoners.
- Cooperating with investigations by the police, Coroner and PPO.

In addition to the above:

- Governors/Directors of contracted prisons should make an initial assessment of what went wrong and put in place immediate remedial action without awaiting the PPO's investigation report. They should not, however, attempt to shadow or duplicate the investigation, which will be conducted by the PPO.
- Establishments must provide an investigation liaison officer, who can be made available to facilitate the PPO's investigation, for example by providing interview rooms, facilitating access to witnesses and preparing copies of documents.
- The PPO may also wish to inspect original documents. There may be occasions when certain documents are unsuitable for disclosure to parties outside the PPO, the prison and the Coroner (see paragraph 1.3 above).

These should be flagged up for further consideration and discussion with the PPO before further disclosure.

- The investigation liaison officer could act also as the inquest liaison officer (See part 6 of PSO 2710). If these roles are kept separate, the inquest liaison officer and the investigations liaison officer will need to work closely together.

- Any requests made direct to the establishment by the police or Coroner for disclosure of documents or information should be complied with immediately. Any such request from other parties (e.g., families or their representatives) should be referred to the PPO's investigating team. This does not apply to provision of a copy of the report and other documents to the Treasury Solicitor, who is the Prison Service's solicitor and acts for the Prison Service at the inquest.

- It is good practice, at the earliest possible stage, to draw to the attention of the PPO any special factors relating to the circumstances of staff involved with the death, of which he should be aware.

145. It is important that the PPO investigator is able to interview staff in a timely way following a death in custody. We make the following recommendations.

**The Governor and Head of Healthcare should ensure that, in line with PSO 2710, all interviews specified by a PPO investigator are arranged with relevant members of staff, including health care staff, in a timely fashion.**

## CONCLUSION

146. The man was only in custody at Pentonville over a weekend. When he went into prison it was clear to staff that he was suffering from mental ill health and heart disease. He was prescribed a GTN spray to keep in his possession but this was never given to him. He was made subject to suicide and self harm procedures because of his intimation that he wanted to kill himself.

147. Over the weekend he obtained a razor blade and cut his wrists. He was then made subject to constant supervision by healthcare. On 13 December, in the early hours, he told staff that he was experiencing heart pain. The nurse who attended him said in her statement to the police that she was unable to examine him because of his aggressive demeanour. Again the investigator has been unable to interview the nurse but has had to rely on an unsigned statement from the police and interviews with other officers who were present at the time.

148. We have found a number of shortcomings in the treatment and care of the man during his short stay at Pentonville. We believe that the outcome might have been different had he been provided with his GTN spray and treated appropriately when he said he was experiencing heart pain. It has also been very unsatisfactory that two key members of staff have not made themselves available for interview.

## RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure a patient who requires "in possession medication" is given it as soon as possible after their reception.

   **This recommendation has been accepted**. The prison say: Patients who are in need of immediate medication are prescribed this on their first contact with healthcare staff in reception. IP assessments are carried out in the first 24 hours of custody and medications will be issued. Emergency medications will be issued but will be subject to risk assessment.

2. The Governor and Head of Healthcare should ensure the expeditious issuing of PIN numbers to healthcare staff so that they can make enquiries about prescriptions, and other health related matters, outside the prison.

   **This recommendation has been accepted**. The prison say: All healthcare staff who are security cleared are issued a PIN number as part of induction. However, when using locum staff an agreed temporary PIN number will need to be agreed to ensure consistency of communication. This will need to be agreed by IT and security managers.

3. The Governor and Head of Healthcare should ensure that a gated cell is available on each wing and, in particular, on the first night centre.

   **This recommendation has been 'agreed in principle**'. The prison say: Safer cells/gated cells on each wing will be subject to a successful funding bid. The healthcare contractor would support this.

4. The Governor should ensure that ACCT reviews are conducted face to face and as a multi disciplinary function, embracing the expertise of specialist staff such as the healthcare team, chaplaincy and others.

   **This recommendation has been accepted.** The prison say: Healthcare contributes daily to ACCT reviews and is a member of the MDT. Healthcare has an up to date operating protocol to support this activity.

5. The Head of Healthcare and the Governor should ensure that all razors are issued and disposed of safely, by a prison officer or member of the healthcare team only.

   **This recommendation has been partially accepted.** The prison say: Process is already in place for one exchange of razors on all residential units. Healthcare staff monitor the issue of razors with expected immediate return after use when risk is identified.

6. The Head of Healthcare and the Governor should ensure that if a prisoner is on an ACCT, they should only be given a razor by an officer, should be supervised whilst using the razor and the razor immediately returned to the officer.

**This recommendation has not been accepted**. The prison say: The ACCT case review must reflect through assessment of risk whether any items of property can be in possession. The risk assessment must clearly demonstrate that all such property/equipment has been assessed and the decision must reflect the risk management plan.

7. The Governor should ensure that all ACCT documentation is fully up to date, with reviews taking place according to PSO 2700, and clear recording of how many conversations should take place and recording of these in the ongoing log.

**This recommendation has been accepted.** The prison say: PSI 64/2011 replaces PSO 2700. This is already in place and reviews monitored by residential management checks of all ACCTs weekly.

8. The Head of Healthcare should ensure that healthcare staff use basic principles to identify risk of physical health in patients with mental health conditions. If nursing staff are fearful of examining a prisoner in this situation they should involve discipline staff and contact senior healthcare managers for support and advice.

**This recommendation has been partially accepted**. The prison say: *There is no evidence of any formal mental health condition in this patient. There was evidence of aggression.*
If any member of healthcare staff cannot carry out their duties due to behavioural problems they have been instructed to always contact the wing discipline staff for support. They must discuss with the senior healthcare staff on duty or use the out of hours managers on call system for advice. Their actions must be recorded on the clinical record and an NHS incident form completed.

9. The Head of Healthcare should ensure that staff are aware that a prisoner who is complaining of chest pain requires access to GTN spray if prescribed, an ECG and observations, and emergency referral to hospital if angina is suspected.

**This recommendation has been accepted.** The prison say: All staff have been trained in managing chest pain. This will include ECG training and competency is tested. Use of GTN spray is part of standard training for management of chest pain and staff are aware they should ensure that a patient with a history of angina would require this medication in possession.

10. The Governor should ensure that staff in reception explain procedures carefully and slowly to prisoners, especially when English is not their first language, using interpretation when necessary, and clarify that the prisoner understands.

**This recommendation has been accepted.** The prison say: This is already in place and highlighted for monitoring and further improvement as part of a project looking at the whole of the first night procedure.

11. The Governor and Head of Healthcare should ensure that, in line with PSO 2710, all interviews specified by a PPO investigator are arranged with relevant members of staff, including health care staff, in a timely fashion.

**This recommendation has been accepted.** The prison say there is now a lead PPO Co-ordinator in place.

12. We urge the Governor and Head of Healthcare to give consideration to the recommendations included in the clinical review.

**This recommendation has been accepted.** The prison say: We will consider all recommendations as requested.