PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man at HMP Pentonville in March 2012

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of an investigation into the death of a man at HMP Pentonville in March 2012. He was found hanging in his cell. He was 48 years old. I offer my condolences to his family and friends.

A clinical review was carried out of the man's healthcare at Pentonville. The prison cooperated fully with the investigation. I apologise for the late issue of this report.

The man had a tragic personal history and lost both his parents when he was very young. He had a long history of substance misuse including alcohol, crack cocaine and heroin and a correspondingly long history of offending linked to his addiction problems. He suffered from a personality disorder and received treatment from mental health services in the community and in prison. He frequently self-harmed by making cuts on his arm.

Many staff at Pentonville were familiar with the man, who had served a number of short sentences at the prison going back some years. Although he could be difficult to manage, he appeared to be at his most stable in the familiar surroundings of Pentonville, with staff he knew, rather than in the community. He was usually very anxious before he was released from prison. Only hours before he was discovered hanging, he had been given a place in a residential rehabilitation unit with a start date of 7 March. This was something he had expressed a strong desire for and apparently regarded as a 'last chance'. The investigation has found no obvious signs that he was planning suicide.

Overall, the clinical reviewer found that there had been good multi-disciplinary working with a clear and coherent approach to meeting the man's mental and physical healthcare needs during his time at the prison. While the investigation identifies some concerns about procedures for checking prisoners at risk in the segregation unit and for calling ambulances, the emergency response in his case was prompt and efficient but, sadly he could not be resuscitated.

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 **September 2013**

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SUMMARY

1. The man had a tragic personal history. His father committed suicide when he was very young and his mother was murdered. He had a long history of substance misuse including alcohol, crack cocaine and heroin. He also had a long history of offending behaviour linked to his problems with addiction. He was diagnosed as suffering from a personality disorder and had spent some time as an in-patient in a medium secure mental health facility.

2. On 26 January 2012, the man was remanded to HMP Pentonville charged with threatening unlawful violence towards others. On 16 February, he was sentenced to 12 weeks in prison with a release date of 7 March 2012. An ACCT booklet (Assessment Care in Custody and Teamwork – to monitor prisoners thought to be at risk of suicide and self-harm) was opened on him in reception after he told staff he was depressed. The ACCT remained open until his death and staff monitored him regularly.

3. The man was initially managed on F wing in the substance misuse unit. He was given Librium for alcohol detoxification and began a methadone maintenance programme which continued until his death. He was transferred to a residential wing on 24 February but complained that he was being threatened by other prisoners and asked to be moved to the vulnerable prisoners unit (VPU) on G wing.

4. On 27 February 2012, the man damaged his cell on G1 landing. He complained to staff that he was receiving abuse from other prisoners and did not want to be on the VPU. He kicked the basin and toilet off the wall and was moved to a cell on G2 landing. He continued to complain that he was the target of abuse. The same evening he kicked the basin off the wall in his new cell and was taken to the segregation unit.

5. Despite being on an ACCT, the man remained in the segregation unit. He appeared to prefer being there and his behaviour was good. He was initially placed on constant watch but had his observations reduced to twice an hour on 29 February.

6. On 2 March, the man attended an assessment meeting with his social worker and staff from Glenholme residential rehabilitation unit. He was given a place in the unit for his release on 7 March. He appeared to be pleased with this but also showed some signs of anxiety about his forthcoming release.

7. In the early hours of the next morning the man was found suspended from the taps in the basin in his cell. He had used shoelaces and a bed sheet to make two ligatures. Staff entered the cell promptly and emergency life support was given. Sadly he was pronounced dead at about 3.30am.

8. We make six recommendations about the frequency of segregation unit and ACCT checks, caremaps, segregating prisoners at risk of suicide and self-harm, auditing complaint forms collected from the segregation unit and the local policy for calling an emergency ambulance.

THE INVESTIGATION PROCESS

9. We were notified of the man's death on 3 March 2012. The investigator issued notices to staff and prisoners at Pentonville informing them of the investigation and inviting anyone with information to contact her. She did not receive any response to these notices.

10. The investigator visited Pentonville on 8 March and met the Governor. She visited the cell where the man died, spoke to an operational manager, the prison family liaison officer and collected copies of his prison record and other relevant paperwork.

11. The local PCT commissioned a clinical reviewer to carry out a review of the man's medical care at Pentonville. The investigator and clinical reviewer interviewed five members of staff together and attended a death in custody review panel on 6 August. We received the clinical report on 29 July.

12. The investigator visited Pentonville on several occasions between 30 March and 18 September and interviewed nine members of staff. After the interviews, she sent feedback to the Governor about the progress of the investigation and emerging issues. She also spoke to the man's social worker and to a member of the Pentonville Independent Monitoring Board. Further information was obtained from the London Ambulance Service.

13. A solicitor spoke at length to the investigator on the telephone on 19 March 2012. He asked that all contact and correspondence with the man's family be directed through him. The family liaison officer and investigator met the man's sister and her previous partner at the solicitor's office on 25 April 2012. The family raised a number of issues at the meeting and in response to the draft report. These have been answered by letter.

HMP PENTONVILLE

14. HMP Pentonville is a local prison serving the courts of North London and holds up to 1,310 prisoners.

15. The NHS provides health services, including substance misuse, mental health and psychiatric care.

Segregation unit

16. The segregation unit is on the lower ground floor of E wing. There are 12 single occupancy cells but the typical occupancy rate is between five and eight prisoners. Working in the segregation unit is seen as a specialist role requiring experience and physical and mental resilience because often the most challenging and damaged prisoners are managed there. Officers are specially selected to work there.

17. The unit is managed by two dedicated segregation unit senior officers who work alternate shifts. There are three officers on duty during the day. At night there is one officer and an operational support grade (OSG). All prisoners in the segregation unit are routinely checked every half an hour, day and night. The checks are recorded on a form headed Pentonville Segregation Cellular Confinement Watch Form.

ACCT (Assessment Care in Custody and Teamwork)

18. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed. Where the perceived risk is lower, the level of observations may be several times an hour or day. Checks should be irregular to prevent the prisoner anticipating when they will occur.

19. Part of the ACCT process involves drawing up a Caremap. A good Caremap will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the Caremap have been completed.

Previous self-inflicted deaths at Pentonville

20. The man's death is the sixth apparently self-inflicted death at Pentonville since January 2010. There are no direct similarities between the circumstances of his death and the others. The investigation into a death shortly after his also made a recommendation about calling emergency ambulances.

HM Inspectorate of Prisons

21. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Pentonville in February/March 2011. HMIP described the size and nature of Pentonville's population as providing "almost insuperable challenges". A quarter of all new receptions were admitted to F wing for detoxification and stabilisation and almost half of those required alcohol detoxification. Drugs and alcohol treatment had improved with the introduction of the integrated drug treatment service (IDTS).

22. The segregation unit regime was described as basic but decent and the staff there generally professional and respectful. Prisoners were positive about their treatment. Staff prisoner relationships across the prison were described as reasonable.

23. Commenting on the ACCT forms checked during the inspection, HMIP found that care plans were not well developed and the timings of observations were often too predictable.

The Independent Monitoring Board (IMB)

24. The Pentonville IMB report for 2011 (the latest available) commented that the segregation unit was "physically grim" but staff managed the, sometimes challenging, population with professional skill. The IMB make regular visits to the segregation unit and complete a weekly review. They speak to the staff and prisoners and monitor the paperwork completed there.

25. The IMB noted the number of prisoners at Pentonville with mental health issues and personality disorders. The limited space in the healthcare centre (22 beds) meant that many less seriously mentally ill prisoners are housed on the wings. The Board noted a limited availability of psychological treatment for prisoners with personality disorders. In general though they concluded that healthcare standards were improving.

Care Programme Approach (CPA)

26. The man was managed under CPA because he had severe and enduring mental health problems. This means that he had a care co-ordinator based in the community who took overall responsibility for monitoring and reviewing all aspects of his mental and physical care in prison and in the community.

KEY EVENTS

27. On 17 January 2012, the man was released from Pentonville after serving a four months sentence for criminal damage. The investigator spoke to the man's social worker and CPA care co-ordinator from the Mental Health Trust's complex care team. She said that he had been anxious about returning to his local authority flat because he had previously experienced problems with local drug users squatting in the property. She said she was initially in regular contact with him but he stopped calling her after only a few days. She later found out that he had spent all the money he was given on release and did not have enough credit on his phone to call her. He appears to have become increasingly distressed at his situation. On 25 January, the police were called to an incident at his home. He was arrested and taken into police custody.

28. The next day, on 26 January 2012, the man appeared at Magistrates' Court charged with threatening unlawful violence towards others. He was remanded into custody and taken to HMP Pentonville the same day. At court, his legal advisor told a Prisoner Custody Officer (PCO) (a member of the court escort staff) that he had told her that he felt depressed about going to prison but not suicidal. The PCO completed a suicide/self-harm warning form (SSHWF) detailing this exchange. This was sent with him to Pentonville. A Person Escort Record (PER) was also sent with him. This showed risk indicators for suicide/self harm, violence to others and drugs. The form also recorded that he suffered from hepatitis C and schizophrenia.

29. At 7.00pm, an officer spoke to the man while he was still in the holding cell in the prison's reception area. He told her that he was feeling low. She opened an Assessment Care in Custody and Teamwork (ACCT) booklet. She wrote on the concern and keep safe form that he had a history of self-harm in Pentonville and appeared very depressed. A nurse interviewed him for his first reception health screen. She noted on his ACCT form that he told her that he had no current thoughts of self-harm. He was then seen by the reception GP who recorded that he had poor eye contact but said he had no intention to harm himself.

30. An IDTS nurse also interviewed the man. His urine test was positive for benzodiazepines and cocaine. He gave a history of daily use of alcohol, diazepam, heroin and crack cocaine. He was prescribed methadone to combat withdrawal from opiates and Librium for alcohol detoxification. Because of this he was allocated to the detoxification unit on F wing. He completed the usual prison induction process. He was categorised as high risk for sharing a cell because of his mental health problems, history of setting fires in his cell or otherwise damaging them and his history of violence.

31. The next day a nurse interviewed the man to complete his ACCT assessment. She wrote that he did not engage very well with her and did not make eye contact. He told her that his life was not going well and he was depressed that he was back in prison. He showed her a gash on his arm that he said he had made a week previously. He told her that voices had told him to do it. He said he did not intend to kill himself when he cut himself, but did it for release

and he was using drugs at the time. He told her that he had attempted suicide in the past but did not elaborate on when and how. He said he had no current plans to commit suicide.

32. The man said he suffered from schizophrenia but was not given medication for this in prison. He told the nurse that his solicitor was trying to get him a place at a rehabilitation facility or supported housing. He said he wanted to get his life back together. He did not feel that he had much of a support network apart from drug workers. She referred him to the prison CARATS (drug support) team, the GP and the mental health team.

33. A care plan (caremap) was completed with the single goal of making sure the man had the correct medication. This was signed as having been completed the same day. It appears from the ACCT on-going record that he was being checked hourly, but this is not recorded on the front of the ACCT or mentioned in the action following assessment section.

34. Also on 27 January, the man was seen by the doctor in charge of the detoxification unit. He attempted to contact the man's community drug worker and the pharmacy from which he obtained his methadone prescription to confirm his dose but without success. (He subsequently managed to do this on 1 February.) The doctor referred him to the prison mental health team because of his history of involvement with them on previous sentences. The doctor, who is a psychiatrist, noted that he could see no signs of psychotic symptoms or thoughts of self-harm. A community psychiatric nurse (CPN) in Pentonville's mental health team contacted the man's social worker by telephone. She advised that she was trying to get him a place in a residential rehabilitation unit on release. She also advised that he should work with the prison's CARATS team as soon as possible.

35. The man had his first CARATS assessment on 30 January. He was reported to be quiet and a bit withdrawn but had plans for the future and was positive about them. He attended what was described as a five day review with different members of the team the following day.

36. On 1 February, the man's social worker visited him, with his solicitor. He told her that he was very keen to be placed in a residential rehabilitation unit on his release. He felt that he could not cope in the community in his own accommodation and would go back to drugs. At interview the social worker said she explained to him that any further incidents of self-harm or violence would not help his application for residential rehabilitation. She agreed to try to find him a place for his release on 7 March.

37. The man's first ACCT case review took place on 2 February. The review was chaired by a Senior Officer (SO) and attended by the man, a nurse (described as a detoxification/mental health nurse) and a member of the CARATS team. He was described as coherent and communicative. He was on his last day of alcohol detoxification. He had been charged with breaking Prison Rules by refusing to leave F wing and move to a regular wing. He complained that he was not receiving the same dose of chlorpromazine (an anti-psychotic that he

was prescribed in low dose as a sedative) that he received in the community. The nurse promised to talk to the GP about this. The CARATs worker told him that he had been given a care in the community grant to receive rehabilitation treatment for his addictions when he was released. He said he was very pleased with this news. He said he did not feel suicidal. The reviewers decided to reduce his observation level to once every two hours.

38. The man's solicitors wrote to the healthcare department in Pentonville on 3 February. They said that his solicitor and social worker had been concerned that he had been slurring his words, making involuntary movements and having difficulty keeping his eyes open during their visit on 1 February. The solicitors said they were concerned that he was not receiving all the medication he had previously been prescribed.

39. On 3 February, the man spoke to a Listener (a prisoner trained by the Samaritans to offer confidential peer support). On 7 February, he had an appointment with his social worker, a community dual diagnosis worker and a psychiatrist. The psychiatrist undertook a therapeutic assessment of him in support of his application for residential rehabilitation.

40. On 7 February, a psychiatrist wrote to the man's solicitors. In his letter, he summarised the medication that he was taking when released. He also said that the community GP practice did not appear to have continued his chlorpromazine but he did not know why. He said that he had assessed him on 27 January and he had shown signs of opiate withdrawal. He agreed with him to increase the dose of methadone until he reached a comfortable dose. He said that his presentation was not as threatening as before. He asked him whether he wanted to transfer to the healthcare centre as usual but he declined. The psychiatrist said that the man had agreed to tell the substance misuse team if he wanted to transfer to healthcare, which he was happy to support. He said he had regular reviews with him and he had not asked to be moved or made any complaints to him about other prisoners or staff. He had also not self-harmed.

41. On 9 February, the man had a further meeting with his social worker as part of the assessment process for his application for residential rehabilitation. This time a member from the community Drug Intervention Programme (DIP) was also present.

42. The man had another ACCT case review on 10 February. He was still on F wing. The review was chaired by a SO and attended by him, a nurse and a member of the CARATS team. He appeared upbeat about the prospect of his drug rehabilitation grant. He said again that he wanted different medication. He said he read a lot to take his mind off things but said he was very worried about his court hearing on 16 February. The review decided to keep his observation level at once every two hours. His electronic medical record shows that the nurse booked him for a medication review for Monday 13 February. This took place as scheduled.

43. On 14 February, the manager in charge of the segregation unit, F wing and safer custody, checked the man's ACCT and asked that the caremap be updated to include actions that needed to be taken to reduce his risk of self-harm.

44. On 16 February, the man was sentenced to 12 weeks imprisonment with an automatic release date of 7 March. He returned to Pentonville from court during the evening and asked for his evening medication. An officer told him that he would have to wait because healthcare staff might not know he had returned. He became agitated and she said she would find out when he would be given his medication. He swore at her and damaged his cell and TV. He was charged with breaking Prison Rules and taken to the segregation unit (on the lowest level of E wing). A nurse completed a segregation safety algorithm which assessed him as medically fit to remain in segregation. She noted that the mental health team would see him the following morning. As he was on an open ACCT, authorisation was obtained from the Deputy Governor.

45. The man had an adjudication (a prison disciplinary hearing) the next day. He pleaded guilty to the charge and received seven days cellular confinement as punishment. He remained on the segregation unit to serve this.

46. At 10.30am the same morning the man attended his third ACCT review. Also present was a SO and a nurse. The SO wrote that the nurse had spent about 15 minutes with him to assess him. He talked about his chlorpromazine and the nurse said he would ask the GP who was due to make the daily segregation unit round about this. He said he was okay and looking forward to his release in three weeks time. No changes were made to the frequency of observations which remained once every two hours.

47. The nurse wrote up his assessment interview with the man on his electronic medical record. The nurse said that he appeared calm, behaved appropriately and was polite. His mood was normal and he told the nurse that he liked being in the segregation unit. The nurse did not see any evidence that he had any thoughts of suicide or self-harm. He asked again about his chlorpromazine. The nurse discussed this with a consultant psychiatrist and he agreed to prescribe it for him. The nurse concluded that he was not clinically depressed or showing any psychotic symptoms. He made a note to review him again the following week.

48. On 19 February, the man asked for a prisoner's complaint form. He told staff he wanted to complain about being bullied. He met the nurse again on 20 February. On 21 February, a person signing their name on the ACCT on-going record (name given) said she spoke to him about concerns he had about his housing in the community and that he appeared reassured after speaking to her. The same day he spoke to a Listener twice. He also started the chlorpromazine prescribed by the psychiatrist.

49. The next day, on 22 February, the man asked for another complaint form. On 23 February, the Segregation manager made a management check of his ACCT and asked a second time that the caremap be updated.

50. The man had another ACCT review on 24 February. A SO and a nurse attended. The SO noted that his cellular confinement in the segregation unit came to an end that day. The SO said that he was apprehensive about returning to a normal cell on a different landing on E wing but was willing to try it. The SO said that he had not self-harmed while in segregation but felt that the ACCT should remain open so that he would have some extra support while he settled in to his new cell. The duty governor gave permission for him to have an extra phone call.

51. The same day the man moved to cell E3-15. An entry on his ACCT record (signature illegible) states that he was happy with his cell and the fact he had a TV. The same member of staff said they had telephoned his social worker for him.

52. The next day, 25 February, the man spoke to a Listener at 7.00pm. At midnight, he told an officer that he would smash his cell up unless he was moved from E wing. The officer spoke to the duty governor and he was moved to cell G2-36 (G2 is a landing designated for overflow from the vulnerable prisoner unit (VPU) on G1 landing). The next day, an officer wrote in his electronic prison record that he had asked to be treated as a vulnerable prisoner for his own protection. He said that at least ten prisoners on E wing were threatening him but would not give their names.

53. An officer made an entry in the on-going record at 7.50pm on 26 February. He said the man had pressed his cell bell and told him that everyone was bothering him. The officer said he was very upset and did not always make sense. He tried to offer advice but said he remained agitated. He said he told him variously that he had been bitten by a cockroach in the segregation unit, was worried about being released and had nowhere to go. He said he did not want to hurt anyone or harm himself. The officer said he seemed calmer when he left him.

54. At 2.00pm on 27 February, the man was moved to a cell on G1 landing (the VPU). His ACCT on-going record shows that he pressed his cell bell on numerous occasions. Officers recorded that he appeared agitated and was pacing about. He asked for some cleaning equipment and spent the rest of the afternoon cleaning his cell. He continued to press his cell bell that evening. At 7.00pm, an officer went to his cell and saw that he had kicked his basin and toilet off the cell wall and they had smashed into pieces. He was holding a table leg. The duty governor and orderly officer were called and he was moved to cell G2-43.

55. At 9.00pm Officer A (signature illegible) wrote on the man's on-going record that he kept pressing his cell bell and asking for tobacco. At 10.00pm, an officer recorded that the man told him he would block his observation panel until he was given some tobacco. At 10.40pm the officer noted that he had

blocked his observation panel. Officers on night duty carry cell keys in a sealed pouch, but only for use in an emergency, so the officer called the Night Orderly Officers, the only staff in the prison who routinely carry cell keys at night, because he needed to go into the cell to unblock the observation panel.

56. Officer B was on duty in the segregation unit that night. He said he heard banging noises from G wing and asked staff who was making the noise. He was told that it was the man and he decided to go and have a chat with him because he had known him for nearly five years and felt he had a good rapport with him. Officer A and Officer C, the Assistant Night Orderly Officer, were also present. Officer C opened the cell and all three of them went in. Officer B asked him what the matter was and he told them that the prisoner next door was shouting at him and he was tired. He said he wanted to move cell. The officer explained that it was night time and the prison was nearly full. He then kicked the sink off the wall and picked up a broken piece of it.

57. Officer C decided that the man should be taken to the segregation unit and put him in handcuffs. Officer B said he walked with them without struggling. A SO was the Night Orderly Officer. She arrived on G wing as the three officers were taking him to the segregation unit. She said she had known him for some years and had spoken to him frequently. She described him as mainly compliant with the officers but said he was shouting a lot. She said she tried to calm him down. He told her that other prisoners had been calling him a nonce and threatening to “get him” but would not name anyone.

58. The SO said that, once he arrived at the segregation unit, the man became tearful and upset. She reminded him that he was being released soon, but he told her that he had no one to go to and nothing outside prison. She said that normally a prisoner on an open ACCT would not be kept in the segregation unit. However, he had damaged two cells and the prison was very full. She spoke to the Duty Governor and it was agreed that he would remain in the segregation unit at least for that night. She said she believed he was comfortable in the segregation unit and his behaviour generally improved when he was there. As a precaution he was placed on constant observation. This meant that an operational support grade (OSG) had to supervise him by looking through his observation hatch all the time.

59. The man was seen by a nurse, who assessed him as fit to be held on the segregation unit. The nurse said that he had no injuries but was crying. He told him that he did not want to go back to G wing because he was being bullied by prisoners because he kept them awake at night. The nurse said he told him he wanted to stay in the segregation unit. He said he promised the SO that he would not harm himself if they let him stay there. The required paperwork was completed.

60. At 9.00am on 28 February, two SOs and the service manager for substance misuse and mental health met to discuss the man. They decided that the level of observation should be changed to five observations every hour until his next scheduled ACCT review that afternoon when a member of the mental health in-reach team would be present. At 12.15pm, an operational manager

wrote on his on-going record that she was content for him to remain in the segregation unit despite the fact that he was on an open ACCT. She noted that he had recently served a period of cellular confinement there without incident. He appeared calmer since being moved from G wing. She said her decision should be reconsidered if he self-harmed or if his ACCT review decided he should be moved.

61. A consultant forensic psychiatrist and a nurse made two attempts to see the man for an assessment and ACCT review. However, another prisoner had flooded his cell and officers were involved in dealing with the incident. It was decided to postpone his review until the following day. He remained on five observations each hour and a nurse was booked to cover the night duty specifically to watch him. Another nurse went to see him during the evening.

62. At 11.00am the next day, 29 February, the man attended adjudications for damaging the cells on G1 and G2. The hearings were adjourned so that he could obtain legal advice.

63. At 3.00pm, the man had his ACCT review with a SO, a psychiatrist and a senior nurse in the mental health team. The SO reported that they had all spoken to him at length. He said the man appeared very agitated and told them that he needed help with housing in the community and did not feel safe on a normal wing. He told them that other prisoners had abused him on G wing and that is why he had smashed his cell basin. He said that sometimes he felt that life was not worth living. The SO said it was explained to him that his social worker was working hard to get him a place in a residential rehabilitation unit. He said he wanted to live his life because he felt he only had 15 or 20 years left. The review decided that he should be observed twice an hour – a check requiring an entry in the ACCT book would take place every hour and the regulation half hourly segregation unit check would count as a second check.

64. The psychiatrist wrote an entry on the ACCT record. He said that the man was angry throughout his review. He told the review that in January he had deliberately re-offended so that he would be returned to prison. He also said that he had smashed the two cells on G wing so that he would be taken to the segregation unit. The psychiatrist said he spoke of impulsive-suicidal ideas but also about having 10-15 years more to live. The psychiatrist said that he did not think he was actively suicidal but might need to have his psychotropic medication reviewed.

65. At interview the psychiatrist said that the man appeared very much the same as when he had encountered him on previous sentences when he had looked after him more closely. He described him as angry, loud, frustrated, talking about how everyone would mess things up by not giving him the support he needed in the community and saying that he might as well harm himself. Later in the ACCT review, he said he was more positive about his future. He said he had no active suicidal plans or intent of harming himself. The psychiatrist said that because he spent some time in the review talking about

his dose of chlorpromazine he asked the nurse to book him a place in his next clinic on 5 March.

66. The nurse wrote up the review on the man's electronic medical record. She described him as appearing agitated, angry, hostile and somewhat paranoid. She said he felt everyone in the prison was calling him a nonce (prison slang for a sex offender). She said he told them that his release date was approaching and he felt that he would be in the same situation again and would have to re-offend. She wrote that he had no clear suicidal intent but had suicidal thoughts. She booked him an appointment with the psychiatrist for a medication review on 5 March.

67. At interview, the nurse explained that she did not believe the man was clinically suicidal when she assessed him that day. He was talking about future plans. Although he had expressed suicidal thoughts, he did not say he was actively suicidal and he was not acutely psychotic. She said that, although his mental state appeared to have deteriorated slightly, she did not think that he needed an immediate intervention. She also spoke to his social worker by telephone, who told her that she had referred him to three residential rehabilitation facilities and was waiting to hear about an assessment date.

68. On the morning of 1 March, a nurse visited the man in his cell. He asked the nurse to contact his solicitor about the two adjourned adjudications, which he did. He also asked for an update from his solicitor on his application for residential rehabilitation. The nurse said that he appeared paranoid that noise from other prisoners was directed against him. He also said officers were "stitching him up" but could not give any specific names or examples. The nurse rang the social worker and left a message for her to call him.

69. That afternoon, the nurse received an email update from the man's social worker and he sent her some relevant information from his prison record in support of his application. At that stage a contingency plan of finding him temporary accommodation in a hostel was also being pursued and the nurse spent some time liaising with staff there.

70. At 9.15am the next day, 2 March, the man attended an assessment meeting with his social worker and two members of staff from a residential rehabilitation unit. Once the assessment was over a nurse joined them. At interview the social worker said she thought that he was unfocused and suspicious throughout the assessment. She thought he looked like he had not slept well. At one point he passed her a note saying that people were out to get him. She said it was not within her remit to become involved with her clients' prescriptions because she is not medically qualified. However, she told the nurse that she thought he needed a medication review and his dosage increased.

71. The social worker said that the staff from Glenholme accepted the man for a place after the interview. She told him that the nurse would confirm absolutely later in the day but he had a place for 7 March. They discussed practicalities

about where he would be able to collect his medication in the community. She said he appeared happy that he had got a place but she thought he was more preoccupied with paranoid ideas that people were out to get him.

72. The nurse wrote in the man's electronic medical record that his social worker had described him as paranoid and agitated during his assessment. The social worker had asked him if his medication could be increased to help him sleep and settle down before his release on 7 March. The nurse visited him twice that afternoon at 2.10pm and 5.20pm. He said he appeared happy that he had got his place at the residential rehabilitation unit. He asked the nurse if he could have some more medication to keep him calm before his release. The nurse said at interview that the man was concerned that he might do something to jeopardise his place at the residential rehabilitation unit. The nurse is unable to prescribe but he saw on the medical record that he had an appointment booked with a psychiatrist on Monday 5 March. The nurse said he did not believe that he was sufficiently anxious to need a more urgent prescription. He was not pacing around his cell and was able to have a normal conversation. The nurse said he had no concerns about his mental state and he appeared to be his usual self.

73. The man was also visited by the CARATS team at 2.25pm. He was seen by a GP during her segregation unit rounds. She recorded that he seemed well and made no complaint about his health. At 5.30pm, after the nurse had visited him, he rang his cell bell. He told the officer (the signature is illegible) that he was sorry for his behaviour earlier in the week and apologised for being rude.

74. The SO on duty on the segregation unit during day shifts that week at interview he said that he had known the man since roughly 2001 and had often managed him both on wings and on the segregation unit. The SO remembered that, during the week leading up to his death, he had been worried about the assessment for his residential rehabilitation place. He said that he and other staff had talked to him about this throughout the week and had tried to give him some advice. Officers had liaised with the mental health team for him and asked them to come and see him if he wanted to speak to them.

75. The SO said the man had described the assessment as his virtually last chance. That morning staff let him out so he could have a shower first. When he returned to the segregation unit he told staff he had been given a place. He said he congratulated him and he and the other officers were pleased for him. He said he appeared pleased but was not as excited as he thought he might have been. He said the man asked him if he could stay in the segregation unit until his release because he was worried that he would do something to jeopardise his place in the rehabilitation unit if he was moved to a wing. He said he reassured him that he could stay in the segregation unit. The SO said that he had not caused management problems that week and had not threatened to harm himself.

The night of the incident

76. Officer B and an Operational Support Grade (OSG) were on night duty on the night of the incident. Both explained at interview that they would take it in turns to make the required segregation unit and ACCT checks on prisoners in the segregation unit and the rest of E wing. Both men had been on night duty together on E wing for that week, beginning on Monday. The officer said at interview that he thought the man had been more unhappy than usual during this sentence. He knew that he had problems outside prison and felt that the segregation unit was his comfort zone, because he knew the staff and the routine and it was a quiet unit compared to the wings. He remembered that he had been on constant watch earlier in the week and had been complaining about not sleeping. He said there was another prisoner in the segregation unit that week who made a lot of noise. The officer felt that he might have thought that he was shouting at him but in fact the prisoner was shouting racist abuse at white officers. The officer had wondered whether his forthcoming release had been playing on his mind. Both the officer and the OSG were aware that he should be observed twice an hour.

77. The OSG said he remembered the man from other wings and over a few years. The week leading up to his death was the first time he had any significant conversations with him. He said he spoke to him every night that week because he liked to get to know the prisoners in the segregation unit. He said he talked quite openly to him and was very polite. He did not notice any change in him during the course of the week.

78. At 9.58pm the officer noted on the ACCT on-going record that the man had asked him for a light for a cigarette. He told him that he was tired but was having trouble sleeping. At 11.00pm, the officer recorded that he was banging his door. He told him that the prisoner in the cell next door was making a banging noise. He said that he checked the cell next door and the prisoner appeared to be asleep. He told him that he would listen out for any banging noises.

79. At 11.58pm, the officer wrote in the ACCT record that the man was sitting on his bed complaining about not being able to sleep. Officer C was on duty as Assistant Night Orderly Officer. On one of his regular rounds of the prison checking prisoners on ACCT forms, Officer B told him that the man had been ringing his cell bell a lot and asked him to speak to him. Officer C said he went to his cell at around 1.00am. He asked him if he was OK. He said he was in a bit of a state and told him that various things were coming through the door and through the sink. The officer tried to calm him down and suggested he tried to get some sleep. He felt he was calmer when he left him because he was sitting on the bed.

80. At his next ACCT check, recorded as 1.00am, Officer B wrote that the man was still complaining that he could not sleep and was kicking his cell door. This is the last entry on the ACCT before his death. At 1.23am, the officer made an entry on the man's electronic prison record. He said that between 8.00pm and 1.25am, he had been pressing his cell bell very frequently. He

wrote that the man had told him he could not sleep and people were not helping him. The officer said he had suggested that he tell the GP that he could not sleep when he saw the doctor on the segregation unit round the next day.

81. The OSG signed the boxes on the segregation unit checklist for 1.30am and 2.00am to confirm he had checked the man. (At 1.48 the CCTV record shows that he spent some time at the cell door talking to him.) No entry was made in his ACCT record after the 1.00am entry. At interview the OSG said that at about 2.00am he was called to do a constant watch on a prisoner on A wing. He could not specifically recall informing Officer B but said that he was certain he would have done.

82. At interview Officer B remembered that he had taken an allowed break at about 2.15am. At about 2.30am he heard a call on his radio asking the OSG to go to A wing to cover a constant watch. He therefore went back to E wing and passed the OSG as he was leaving the wing. He said he decided to check the paperwork to see whether the OSG had made the 2.30am segregation unit checks before he had left. He saw that the 2.30am box was blank and so began to make the checks himself. He thought it was about 2.45am by this time. He looked into the man's cell and saw that he was hanging from the taps in his basin.

83. The officer said that he immediately used his radio to call an emergency alarm. He broke the sealed pouch containing his cell key and went into the cell. He was very closely followed by the SO and two officers. The SO and Officer D used their cut down tools (which all officers carry) to release the man from the ligature around his neck, which he had made from shoelaces and a bed sheet. He was then laid on his back on the cell floor and Officer E checked for signs of life while Officer D removed the last piece of shoelace from his neck. Officer E, a trained first aider, could not find any signs that he was breathing so she began chest compressions. She said that he made a distressing noise that sounded as if it was coming from a dead person. She said she felt too distressed to continue and left the cell. Officer D, who was also a trained first aider, took over.

84. The designated emergency response nurse that night was in C and D wing treatment room when he heard the level one emergency call. He picked up the emergency bag and oxygen and ran to the segregation unit. He said he found the man on the floor with an officer doing chest compressions. He checked for a pulse but could not find one. He asked the SO to ring for an emergency ambulance and took over chest compressions. The nurse said the man was cold to the touch. He put a breathing mask on him and attached it to the oxygen cylinder, which Officer C held. He received 30 chest compressions to two breaths. A nurse arrived from reception and he asked her to bring a defibrillator from C and D wing.

85. An ambulance was called at 2.48am. The SO went to the centre (the area that the wings open on to), unlocked the key safe, gave the North Wall gate keys to an officer and an OSG and told them to go to the North Wall gate to

let in the ambulance staff when it arrived. The nurse brought the defibrillator and the emergency response nurse attached it to the man. It advised no shock but to continue CPR. (A defibrillator detects heart rhythm and will only advise a shock if it detects one.) The nurse inserted an airway to help get oxygen into him. She also tried to find a vein to prepare him to receive intravenous fluids from the paramedics. She was unable to find one and described him as cold to the touch.

86. The prison incident logs show that the first response paramedics arrived at the North Wall gate at 2.58pm and at the cell at 3.02am. A second ambulance crew arrived at the gate at 3.04am and at the cell at 3.07am. The paramedics took over cardiopulmonary resuscitation but the man was pronounced dead at 3.34am.

CCTV

87. The CCTV for the two hours between 1.00am and 3.00am shows:

- 1.02am: Officer B looks through the man's observation panel and writes on the segregation unit watch form in the box outside his cell. He does the same for other cells.
- 1.32am: the OSG looks through the man's observation panel and writes on his segregation unit watch form. He does the same for other cells.
- 1.42am: the OSG returns to the man's cell and spends over a minute talking at the door. He walks away a few paces then returns and writes on his segregation unit watch form. He then does the same for other cells.
- 1.48am: the OSG returns to the man's cell and spends over a minute talking to him at the door. He does not write on the segregation unit watch form and he does not check other cells before leaving the wing.
- 2.46am: Officer B looks through the observation panels. After checking the man's cell he uses his radio.
- 2.47am: Officer B enters the man's cell (19 seconds after discovering him). Other staff run on to the wing and enter the cell five seconds after the officer.
- 2.48am: The emergency response nurse enters the man's cell (One minute 14 seconds after the emergency radio message).

Prisoner support

88. All prisoners with open ACCT forms were reviewed the following day. Notices were put up throughout the prison giving the news of the man's death.

Staff support

89. A hot debrief for all staff in attendance was held that night. At interview all staff apart from one said they found the debrief helpful and were satisfied with the support received from management after the man's death. The member of staff who was unhappy said he had made his concerns known to management. He felt that extra night staff should be deployed on nights following a death in custody to support those who had been involved in the emergency response. He felt that promises made in this regard had not been kept.

Family liaison

90. The next morning an operational manager and a prison chaplain went to the man's sister's house to break the news of his death. They were accompanied by local police. His sister was not at home and the operational manager left his contact details there. The local police officer returned to the man's sister's house in the afternoon and broke the news of his death to her. The operational manager spoke to her shortly afterwards by telephone. The Governor wrote a letter of condolence to the family.

91. The operational manager telephoned the man's sister on several further occasions during March. He explained the inquest process and the process of this investigation. The prison offered financial assistance with the funeral in line with National Offender Management Service guidance. The operational manager visited the man's sister to return his prison property.

The man's complaints

92. Two confidential access complaints completed by the man and dated 22 and 28 February were collected from the complaints box in the segregation unit on Monday 5 March, two days after his death. (When prisoners want to make a complaint about any aspect of their treatment they complete a form and put it in the locked complaints box on the wing. The boxes should be emptied daily and the forms given to the prisoner's complaints administrative officer who logs them and distributes them to those best placed to reply. Confidential access complaints addressed to the Governor should go directly to him or her to decide what action to take.)

93. An operational manager undertook a local investigation. The members of staff responsible for emptying the complaint boxes were interviewed and CCTV was studied from 2 March. A member of staff said she had emptied the segregation unit complaint box at 12.30pm on 2 March. CCTV did not pick her up on the unit at this time. The investigation concluded that it was not possible to say how long his complaints had been in the box.

94. In the first complaint form, serial number PVBM/12/576, dated 22 February, the man said that he had smashed his cell up because he was on the wrong medication for his mental illness. He therefore felt that it was inappropriate to punish him at adjudication.

95. In the second complaint form, serial number PVBM/12/575, dated 28 February, the man said he was being bullied and singled out by staff and prisoners. He said he was kept awake at night by another prisoner banging on his wall. He said that staff only laughed at him when he complained and he felt like ending his life.

ISSUES

Checks by night staff on the night of the incident

96. In the segregation unit in Pentonville every prisoner is routinely checked twice an hour. These checks are recorded on a segregation unit watch form pre-printed with the time of every hour and half hour. According to the front of the man's ACCT document he was required to be checked hourly supported by a half hourly segregation unit check. The intention was that he would be checked twice every hour. Because he would automatically be checked twice every hour as a segregation unit prisoner it was decided that the first of these would double up as the ACCT check. This check would be recorded both on the ACCT document and on the segregation unit watch form. The second segregation unit check would only be recorded on the segregation unit watch form. The segregation unit watch forms are in a box on the wall outside each cell.

97. The CCTV footage shows that Officer B checked the segregation unit prisoners at 1.02am. He signed the man's segregation unit watch form in the box labelled 1.00am. He also made an entry on his ACCT document timed at 1.00am. This is the last entry on the ACCT document. The OSG checked the prisoners at 1.32am and signed the 1.30am box on the man's segregation unit watch form. He returned to the cell at 1.42am. After speaking to him for over a minute he took a few paces away and then returned and wrote on his segregation unit watch form. It seems likely that this is the entry he made in the 2.00am box on that form, because CCTV shows he did not write on the form after this. He then checked the other prisoners. This is the last time that the man had a written observation before the officer discovered him hanging at 2.46am.

98. The CCTV footage shows that the OSG returned to the man's cell at 1.48am and spoke to him through the door for over a minute. He went directly to his cell, did not write on the segregation unit watch form afterwards and did not check any of the other prisoners. This is the last time that he was seen by anyone until the officer discovered him hanging at 2.46am.

99. The OSG and Officer B give different timings for what happened that night. There is no doubt that the OSG was called to a constant watch on A wing and was not on the wing when the man was found. Whatever the exact sequence of events, the requirement was that the man was checked twice an hour. This is also what both night duty staff understood to be the requirement. All of the checks made during the evening duty that night until 1.32am followed the same pattern – two checks were made every hour shortly before or after the hour and half hour mark, the first check was recorded on both the ACCT and the segregation unit watch form and the second only on the segregation watch form. At 1.42am the OSG checked him and made an entry on the segregation unit watch form (in the 2.00am box). He did not make a corresponding entry on the ACCT document. There is no '2.00am' entry on the ACCT document as had been the previous pattern.

100. According to CCTV, it was therefore one hour and three minutes between the last recorded check on the man's segregation unit watch form and him being found hanging, and 58 minutes between this and the time he was last seen alive at 1.48am. Therefore in the last hour before he died he was not checked as required by Pentonville's own procedures for people in segregation.

101. We believe that the pre-printed times on the segregation unit watch form simultaneously encourages predictability in the checks and gives an inaccurate account of the time they are made. It appears from the pattern of checks on the night the man died that prisoners in the segregation unit could be sure of a certain period in every half hour when they will not be checked at all. This means a prisoner determined to kill himself will use that opportunity. It also means those who self-harm as a cry for help and are hoping to be discovered might rely too much on that predictability. We make the following recommendation:

The Governor should ensure that the form used in the segregation unit to make checks is amended to remove the pre-printed time slots and give clear instruction to staff that the twice hourly checks should be made at random times.

ACCT

102. Examination of the man's ACCT document shows that the entries on the on-going record were generally of good quality and reflected that staff took time to have conversations with him. It was opened appropriately when he arrived at the prison as he was found to be depressed.

103. We do not consider that segregation units are usually appropriate places to hold prisoners at risk of suicide and self-harm and it is unfortunate that Pentonville do not appear to have considered more fully whether he would have been more appropriately located in healthcare. We understand that the options at Pentonville are very limited. The decision to segregate the man was properly documented and it appears to have met his needs for a quieter environment away from the main residential wings. Nevertheless, a segregation unit allocation for a prisoner considered at risk of suicide and self-harm should always be a last resort. There were frequent management checks and Night Orderly Officer checks, one of which corrects a poor handover to the nurse when he was on constant observation. However, we note that on 17 February, he received a punishment of seven days cellular confinement, when Prison Service guidance is that such a sanction should be avoided whenever possible for someone at risk of suicide and self-harm. As he was already living in the segregation unit it is not clear what distinction this meant to his living arrangements.

The Governor should ensure that prisoners who are at risk of suicide and self-harm are not held in the segregation unit unless exceptionally they are such a risk to themselves or others that no other location is appropriate.

104. ACCT reviews were multi-disciplinary and were always attended by mental health staff and wing staff, but the caremap had only one goal of ensuring that the man was prescribed the correct medication. This was ticked as completed the same day the ACCT was opened. Effectively this means that his ACCT was left open with no plan of how to reduce his risk of self-harm or what support he needed in order to be kept safe. On two occasions an operational manager wrote on the ACCT record asking for this to be improved but no changes were made as a result. HMIP also commented in the last inspection report, that caremaps were poor. Work was done with the man and he had good input from the mental health team co-ordinated with his CPA. This should have been reflected in the caremap. We noted that there was some inappropriate language on the ACCT record which was not indicative of a supportive approach. For example on one occasion he was described as "whinging".

The Governor should ensure that ACCT caremaps set effective targets which reflect their level of risk and the triggers of their distress and address their identified needs.

105. Because the ACCT checks followed the pattern for segregation unit checks, the checks on the man's ACCT form were too predictable, but the last check was not recorded at all. Generally they appear to have taken place at the same time each hour. Guidance is that checks should be made at irregular times so that prisoners are not able to predict when they are checked. We note this was also a point made by HMIP in their inspection of 2011.

The Governor should ensure that all open ACCTs are reviewed to ensure that checks are being made at random times within the period specified. The Governor should also ensure that all ACCT training reinforces this point.

The emergency response

106. Officer B broke his sealed pouch and entered the man's cell as soon as he had called for assistance on his radio. Other staff arrived within seconds and the emergency response nurse within one minute 15 seconds. Three of the staff who responded first were trained first aiders. Emergency medical equipment was brought promptly. The correct number of breaths to chest compressions was given. The response was prompt efficient and co-ordinated

107. At interview, staff said that the Night Orderly Officer checked at the beginning of the week which staff on duty were first aid trained. In our experience, this is unusual and we consider it a good arrangement.

Calling an ambulance

108. Pentonville's local policy on calling ambulances in emergency situations stipulates that an ambulance can be requested by the duty doctor, healthcare manager, orderly officer or duty governor. Of the people listed only the

orderly officer is present at night. In the man's case the emergency response nurse asked for an ambulance as soon as he arrived at the cell, which was sufficiently prompt for there to be minimal delay.

109. However, Pentonville's local policy is contrary to Department of Health and National Offender Management Service guidance. This guidance was updated in a letter of 17 February 2011 from the Director of Offender Health at the Department of Health and the Chief Executive of the National Offender Management Service which went to the governors of all prisons. This required governors to ensure that a protocol exists at each prison to ensure immediate access of ambulances to prisons and to the individual prisoner. Any member of staff raising the alarm should be able to call for an ambulance. We are satisfied this caused no delay in the man's case but it is important that all staff should understand they should request an ambulance whenever there are serious concerns about the health of a prisoner without waiting for a designated member of staff to attend or authorise it. In case there is any confusion caused by the local policy we make the following recommendation:

The Governor and Healthcare Manager should revise the local policy on calling ambulances to ensure that it corresponds with national guidelines that an ambulance can be called by any member of staff.

The clinical review

110. The clinical reviewer gives a comprehensive summary of the mental and physical care received by the man in Pentonville during his last three sentences between 17 September 2011 and 3 March 2012. He also summarises the opinions offered at interview with the consultant forensic psychiatrist, the associate specialist psychiatrist and two nurses.

111. He concluded that the testimony of all of the mental health staff responsible for the man demonstrated dedication and genuine concern for his well-being. It was apparent at interview that he was well known at Pentonville and his death affected several staff personally.

112. The clinical reviewer concluded that the man received good clinical care at Pentonville, equivalent to that he would have received in the community. He concluded that his mental health needs in particular were approached with sensitivity and genuine concern for his wellbeing. The recommendations contained within the NICE (National Institute for Clinical Excellence) guidance for the treatment and assessment for people who self-harm were followed. The multi-disciplinary working within the prison was good, especially between his social worker and a nurse (RMN). All of the clinical records suggested a clear and coherent approach to his care.

113. He concluded that the attempted resuscitation of the man was swift and followed correct procedure. He also considered that his hanging was unforeseeable and not preventable.

Complaint forms submitted by the man before his death

114. The man's ACCT record shows that he was given complaint forms on 19 and 22 February. When he asked for one on 19 February he told staff he wished to complain about being bullied. The investigator was shown two other complaint forms, one dated 18 February that he did not appear to have submitted and one dated 19 February that had been answered by the Governor.

115. It is not possible to say with certainty when the man submitted the forms dated 22 and 28 February that were found on 5 March. It is possible that he put them in the locked box after 12.30pm on 2 March when the member of staff remembers emptying it.

116. The man told people, including a nurse and his social worker, quite often that he was being bullied by staff and picked on by prisoners. When asked to give names and examples, he did not to do so, which made it difficult for staff to investigate. On the night he died he complained that the prisoner next door to him was banging on the wall. Officer B looked through the observation panel of the cell next door and the prisoner appeared to be asleep. As he had a paranoid personality disorder it is possible that this caused his confusion.

117. We were unable to find any evidence during the investigation that the man was being bullied or victimised by staff or other prisoners at Pentonville. Nevertheless it is a concern that we cannot be sure that complaints about bullying from a prisoner in the segregation unit were dealt with as promptly as they should have been.

The Governor should ensure that an auditable system is introduced to confirm that complaints are collected from the segregation unit daily.

Issues raised by the man's family

118. The man's family asked why he was held on the vulnerable prisoner unit before moving to the segregation unit. According to the records, at midnight on 25 February, he told staff that he wanted to move from E wing because he felt threatened by other prisoners. He was moved to G2 landing, which is the overflow landing from the vulnerable prisoner unit on G1. The next day an entry on his electronic prison record shows that he asked for vulnerable prisoner status. He was then moved to the vulnerable prisoner unit that day.

119. The man's family asked why he was kept on the segregation unit when he was on an open ACCT. The investigation found that he himself was keen to move to the segregation unit. He found the normal wings too busy and distressing and he was very opposed to being held on the vulnerable prisoner unit. During previous sentences, he had either lived in the segregation unit or on the healthcare centre. The investigation is satisfied that he was located in the segregation unit initially because staff had no option after he damaged two cells on G wing on the same night. The decision was clearly thought through by senior management and safer custody staff and steps were taken to

ensure his safety – even putting him on constant observation initially. A SO told the investigator that he was keen to remain on the segregation unit until his release. The investigation has seen no evidence that his location on the segregation unit contributed to his actions on the night of the incident.

120. The man's family asked why his medication was not increased on 2 March after his social worker reported an increase in his anxiety levels. He was seen twice by a nurse in the afternoon of 2 March. The nurse did not consider that he was sufficiently anxious to need an immediate review of his medication. The clinical reviewer is satisfied that this was a reasonable assessment. No other staff who came into contact with him on 2 March thought that he was any different in terms of his presentation to how he was usually. Several of these staff knew him well. He was seen by a prison GP during the daily GP rounds that day. He did not complain to her and told her he was well.

121. We can confirm for the man's family that he was on a methadone maintenance programme at the time of his death. At interview the associate specialist psychiatrist confirmed that this also impacted on the amount of medication he was given to reduce his anxiety levels.

122. The man's family asked if he had an Offender Manager (probation officer) and, if so, what was their involvement in his care. He did not have an Offender Manager because his most recent sentence was of less than 12 months duration. His previous two sentences were also less than 12 months so he had not been released from Pentonville on a supervision licence.

CONCLUSION

123. The man was clearly distressed about his life. He appears to have been anxious about release and despairing of his frequent returns to prison, which he saw as inevitable without proper support in the community. Despite a long history of self-harm he had no previous history of attempted suicide. Although his pattern of self-harm, suicidal thoughts and personal history placed him in a higher risk of attempting completing suicide, we do not believe there was cause for staff to expect his death on 3 March. All the staff involved in his care were aware that he usually became anxious about release, but on this occasion everyone was reassured by his placement in residential rehabilitation. He was subject to apparent regular watches in the segregation unit for most of the evening and night of his death but it is a concern that he does not appear to have been checked for almost an hour at the time he hanged himself.

124. This is a sad story. The man had many issues that meant that he could be a challenge to manage. We are satisfied overall that he received a good standard of care at Pentonville and that there were no signs that he would attempt suicide on the night he died.

RECOMMENDATIONS

1. The Governor should ensure that the form used in the segregation unit to make checks is amended to remove the pre-printed time slots and give clear instruction to staff that the twice hourly checks should be made at random times.

   The prison accepted this recommendation and said:
   "Check sheets have been amended and are now in place. Each check sheet also now has instructions on it about random check times."

2. The Governor should ensure that prisoners who are at risk of suicide and self-harm are not held in the segregation unit unless exceptionally they are such a risk to themselves or others that no other location is appropriate.

   The prison accepted this recommendation and said:
   "All prisoners considered for the Segregation who are subject to an ACCT are reviewed by the Governor. All alternative arrangements are considered, but if it is decided that a prisoner should remain in the Segregation, whilst on an ACCT, they will be placed on constant supervision."

3. The Governor should ensure that ACCT caremaps set effective targets which reflect their level of risk and the triggers of their distress and address their identified needs.

   The prison accepted this recommendation and said:
   "All staff are trained in basic ACCT procedures. Case managers who write the caremaps have been trained by the Safer Custody team and are aware of their responsibilities. This training is ongoing. Management checks are carried out by the Safer Custody team to ensure caremaps are appropriate."

4. The Governor should ensure that all open ACCTs are reviewed to ensure that checks are being made at random times within the period specified. The Governor should also ensure that all ACCT training reinforces this point.

   The prison accepted this recommendation and said:
   "ACCT training is carried out regularly and notices have been sent out regarding this point. The Safer Custody team carry out checks to ensure this is being adhered to."

5. The Governor and Healthcare Manager should revise the local policy on calling ambulances to ensure that it corresponds with national guidelines that an ambulance can be called by any member of staff.

   The prison accepted this recommendation and said:
   "This is in the process of being addressed by the Safer Custody lead and Head of Healthcare to ensure compliance."

6. The Governor should ensure that an auditable system is introduced to confirm that complaints are collected from the segregation unit daily.

The prison accepted this recommendation and said:
"New complaints log in place in the Performance Office specifically logs daily checks of the Segregation Unit."