

**Independent investigation report by the
Prisons and Probation Ombudsman
Nigel Newcomen CBE
into the death of a man,
a prisoner at HMP Pentonville,
in December 2014**

Our Vision

*To carry out independent investigations to make custody
and community supervision safer and fairer.*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man was found hanged in his cell at HMP Pentonville on 5 December 2014, and died in hospital a few days later. He was 33 years old. I offer my condolences to his family and friends.

The investigation found that, although the man had a number of risk factors, these were not sufficiently obvious to indicate that staff at Pentonville needed to begin Prison Service suicide and self-harm prevention procedures. On 5 December, he was very agitated and rang his cell bell a number of times. Another prisoner said he heard him threatening to kill himself. I consider that the officer, who dealt with him, should have done more to identify and address the cause of his distress and try to calm him. Later in the afternoon, no one answered his cell bell for 24 minutes, during which he hanged himself. Leaving an upset prisoner for so long without responding to a cell bell is unacceptable.

I am concerned that, contrary to national instructions, the control room officer did not immediately call an ambulance, when an emergency alarm was raised. New procedures at Pentonville have been introduced to address this issue and I am satisfied that this did not affect the outcome for the man, as the resuscitation attempt was prompt and competent. There was a delay of two days in informing his family of his admission to hospital, which the prison could have avoided by using information from his prison telephone account.

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

August 2015

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SUMMARY

Events

1. The man had a history of alcohol, heroin and cocaine dependence, and had served a number of prison sentences for crimes related to his substance misuse problems. He had attempted suicide more than once outside prison and had spent time in a psychiatric hospital.
2. On 31 October 2014, the man was arrested and charged with burglary and attempted burglary. He was remanded to HMP High Down and started a methadone maintenance programme. On 21 November, he was convicted and taken to HMP Pentonville. He lived on A Wing, the prison induction unit, and refused to move to a wing dedicated to prisoners receiving treatment for substance misuse.
3. On 5 December, the man again refused to move wings and was verbally abusive to an officer. Staff placed him on the basic regime and removed his television from his cell. He had been expecting to go to court that day and was apparently angry that he had not gone.
4. During the afternoon, the man pressed his cell bell a number of times and an officer answered it. Another prisoner said he had heard him threaten to kill himself, but the officer took no action. At 2.54pm, he rang his bell a final time but it was not until 3.18pm that an officer responded and found he had hanged himself. He was taken to hospital, but died a few days later.

Findings

5. Although the man had a number of risk factors, there was little to indicate that his level of risk was such as to make it clear that staff should have begun Prison Service suicide and self-harm prevention procedures (known as ACCT). The officer who answered his bell several times on 5 December had insufficient information to recognise that he might be at increased risk and seemed to consider he would need to self-harm before he could open an ACCT.
6. The man was clearly agitated on 5 December, and the officers who dealt with him should have done more to identify and address the cause of his distress and de-escalate the situation. There was an unacceptable delay in answering his cell bell and a swifter response might have saved his life.
7. Staff in the control room did not call an ambulance immediately in response to the medical emergency. However, we are satisfied that this did not affect the outcome. Pentonville had now introduced new procedures to address this.
8. Pentonville did not contact the man's family until 7 December because they could not find any contact details. In fact, contact details were contained in his prison telephone account. The prison should have used these to contact his next of kin as soon as he was taken to hospital.

Recommendations

- The Governor and Head of Healthcare should ensure that staff consider all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from prison and medical records and other documents and that staff understand the circumstances when they should consider opening an ACCT, including when a prisoner has expressed suicidal intent.
- The Governor should ensure that all cell bells are answered within five minutes and that when prisoners ring their bells repeatedly, staff make active attempts to engage with them to de-escalate the situation and address the underlying cause.
- The Governor should ensure that prisoners' families are informed as soon as possible when prisoners are seriously ill in hospital and that staff check all sources of information when there is no recorded next of kin.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
10. The investigator visited Pentonville on 15 December 2014. She obtained copies of relevant extracts from the man's prison and medical records.
11. The investigator interviewed nine members of staff and five prisoners at HMP Pentonville in February 2015 and one at HMP Warren Hill in March. An assistant Ombudsman interviewed one officer on 31 March. The investigator spoke to a spokesperson from Static Systems, the company that supplies and maintains Pentonville's cell bell system.
12. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer and investigator interviewed four members of staff together.
13. We informed HM Coroner for Inner North London District of the investigation and have given her a copy of this report.
14. One of the Ombudsman's family liaison officers contacted the man's parents and sister to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The man's sister asked us to clarify:
 - Whether he was subject to monitoring.
 - Whether his cell bell had been working on 5 December, and if he had pressed it that day.
 - Whether the light outside a cell turns on when a cell bell is pressed.
 - Details of the emergency response and the time he was found hanging.
 - Why it had taken until 7 December to tell his family that he was in hospital.

The family received a copy of the draft report. They pointed out one factual inaccuracy in the clinical review and we have amended it accordingly. The family also raised three questions that do not impact on the factual accuracy of this report. These have been addressed through separate correspondence.

BACKGROUND INFORMATION

HMP Pentonville

15. HMP Pentonville is a local prison that holds close to 1300 young adult and adult men. The prison primarily serves the courts of north and east London.

Her Majesty's Inspectorate of Prisons

16. The report into the most recent inspection of Pentonville in February 2015 has yet to be published. However, we understand from initial feedback that inspectors had concerns about the levels of violence and safety at the prison. Inspectors observed healthcare staff respond to two emergency calls in a rapid and professional manner. They noted that suitable well-checked emergency equipment, including automated external defibrillators, was strategically placed across the prison. An ambulance was called promptly in emergencies. At the previous inspection in September 2013, inspectors observed long delays in officers answering cell bells and noted that this had also been the case at earlier inspections.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 March 2014, the IMB reported that staff reductions had resulted in a less decent and less safe prison. Staff had less time to interact with prisoners and constructive activity had been sacrificed to try to establish a secure and safe regime. The IMB said, "Officers, under pressure to maintain a safe environment, are less attentive to individual prisoners and their problems, resulting in potentially dangerous levels of frustration and dissatisfaction ... "

Previous deaths at HMP Pentonville

18. The man's was the first self-inflicted death at Pentonville since April 2013. In that investigation report and the report of an investigation into a death from natural causes in June 2014, we made a recommendation that the local emergency response policy should reflect the requirements of Prison Service Instruction 03/2013 and that the control room calls an ambulance immediately an emergency code is called. Since his death, the senior manager responsible for safer custody has agreed a protocol with the London Ambulance Service and updated the local policy.

Incentives and Earned Privileges (IEP) Scheme

19. Each prison has an Incentives and Earned Privileges scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff.

Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Assessment, Care in Custody and Teamwork (ACCT)

20. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

21. The man had a history of dependence on alcohol, cocaine and heroin, and had served a number of prison sentences for crimes related to his addictions. He suffered from depression and had attempted suicide several times in the community. In August 2013, he took an overdose of antidepressants when facing eviction from his home. He was admitted to hospital and diagnosed with emotionally unstable personality disorder. In November 2013, he jumped off a balcony after splitting up with his girlfriend.
22. At an initial health assessment in HMP Thameside on 29 November 2013, the man told a nurse about his recent suicide attempt and said he was depressed. The nurse began Prison Service suicide and self-harm prevention procedures, known as ACCT. He told a GP that he had jumped off the balcony in frustration. On 6 December, officers closed the ACCT after he said he was back with his girlfriend and felt in better spirits. According to his medical record, after he was released from prison, he took two further overdoses in December 2013 and January 2014.
23. The man was remanded to Thameside between 22 and 25 March 2014. In his initial health assessment, he said he had taken an overdose five months previously but had not otherwise harmed himself outside prison. He was remanded to Thameside again on 28 May 2014. On 2 June, he told a nurse that he had a history of mental health problems and self-harm including taking an overdose. Thameside received his community medical notes on 17 June, and scanned them into his prison medical record. The community medical notes contained brief details of his history of self-harm. On 25 July 2014, he was released from Thameside.
24. On 30 October 2014, the man was charged with burglary and attempted burglary. A police medical officer completed a risk assessment the same day. He said he was dependent on alcohol, cocaine and heroin. In response to a question about suicide or self-harm, he said he had headbutted a wall a few months before. On 31 October, he appeared at Magistrates' Court and was remanded to HMP High Down. Police noted on the Person Escort Record (PER) which accompanied him from the court to the prison, that he had attempted suicide in 2005 (it is not clear where this information came from) and had headbutted a wall.
25. At a first night interview at the prison, the man told an officer that he had taken an overdose six months before. He said he did not currently feel suicidal. At an initial health assessment, he told a healthcare assistant that he had never attempted suicide or self-harmed. He again said that he did not currently feel suicidal. A substance misuse nurse and a prison GP assessed him and he started a methadone maintenance programme (as a substitute for heroin).
26. On 21 November, the man was convicted at Crown Court and taken to HMP Pentonville to be sentenced later. The suicide and self-harm box on his escort record (PER) noted that he had not been on an ACCT since December 2013, but did not mention his previous suicide attempts.

27. At an initial health assessment, the man told a nurse that he had no history of mental health problems, no history of attempted suicide or self-harm and did not currently feel suicidal. She told the investigator that she had not read his medical record from previous sentences. She said that he was calm, cooperative and did not seem to be suffering from substance withdrawal. A specialist doctor in substance misuse examined him and continued his methadone maintenance programme.
28. The man gave his consent to allow Pentonville access to his community medical notes. Staff requested them on 26 November, but they had not arrived at Pentonville before he died.
29. The man had a double cell on A Wing, the first night and induction wing. Because he was receiving methadone, he would usually have gone to E or F Wings, which are dedicated substance misuse wings. There is no record of why he went to A Wing, but it is possible that there were no spaces on E or F Wing when he arrived. Priority for places on E or F Wing is given to prisoners who are withdrawing from alcohol or have just come into custody.
30. On 23 November, the man refused to transfer to E or F Wing. He told an officer that he had issues on E and F Wing but did not explain what these were. She noted on his prison record that she had checked for prisoners on E and F Wing with known associations with him, but had not found any.
31. On 24 November, the man told a nurse that he was not stable on his dose of methadone but did not want to increase it. He said he planned to reduce the dose when he became stable. He was expecting to go to court two weeks later and thought he might move to HMP Thameside.
32. On 28 November, a case manager with Phoenix Futures (a drug and alcohol recovery service at Pentonville) assessed the man. She told the investigator that she had met him in the community in October 2013, when she was working at a Drug Intervention Programme. She remembered that he could be aggressive when he became frustrated and he would talk loudly, swear and disengage. She had access to his medical record, but had not read it before meeting him and did not know that he had previously attempted suicide.
33. The case manager said the man recognised her when they met on 28 November and was pleasant, polite and well mannered. He told her that, before arriving at Pentonville, he had completed an assessment and was hoping to be released on a Drug Rehabilitation Requirement (DRR, a community based court sentence designed to assist drug users appearing before the courts for offences resulting from their drug use). The assessment, a pre-sentence report and a guilty plea were all necessary for the court to make their decision. She said that he knew that he would not get a decision about the DRR for a little while as not all of the reports had been submitted.

34. The case manager said the man had a level of stress appropriate to his circumstances. He told her that he thought he had depression but said this was undiagnosed. He said he had overdosed on his partner's anti-depressants about a year previously when they had been facing eviction. After the assessment, she faxed his community drugs worker to say he was in custody and working with recovery services.
35. The case manager said the man gave her no impression that he was at risk of suicide or self-harm. She said a DRR was quite a commitment and very forward looking, and that he appeared motivated towards securing one.
36. On 1 December, an officer wrote in the man's prison record that he had been loud, obnoxious and obstructive at the end of association time (when prisoners are allowed out of their cells to socialise with each other). She gave him a warning under the Incentives and Earned Privileges (IEP) Scheme.
37. On 2 December, the case manager visited the man in his cell to show him a letter she had prepared for the court, as evidence that he was working with the recovery service. She told him she had been in contact with his community drugs worker. He said he felt stressed but told her it was a personal matter and he did not want to talk about it. She offered him some time out of his cell to discuss it, but he said he did not want to. She said he was expecting to go to court on 5 December, and she thought that might have been the cause of his stress. She reminded him that she was working with his community drugs worker and encouraged him to remain calm and rational.
38. On 3 December, an officer said the man had told him to fuck off after he had asked him to go back to his landing at the end of an exercise period. The officer said he and a colleague escorted him back up the stairs. He stopped on the fourth landing, sat down and told the officers they were threatening him. Another officer joined them and the three officers walked him back to his cell. The first officer gave him a second IEP warning.

5 December 2014

39. At about 8.00am, Officer A unlocked the man's cell and Officer B took him to E Wing, where he collected his methadone each day. Officer B said the man was "good as gold". He did not seem upset and did not mention the incident on 3 December.
40. Officer A was responsible for moving prisoners who had completed their induction to other wings to free up cells for new receptions. Because he had unlocked him to collect his methadone, he said he knew that the man was eligible to move to E or F Wing with the other prisoners receiving substance misuse treatment.
41. At about 10.00am, Officer A went to the man's cell and offered him a move to either E or F Wing. The officer said he refused to move and was verbally abusive and shouted at him. He said he tried to find out from him why he was unwilling to move, but he did not give him any reasons. He said the man told

him to fuck off and to go back to his own country. Officer C joined him and they tried to reason with the man, but he continued to be abusive. Officer A told him he would be placed on a disciplinary charge for refusing to move wings, and gave him a third IEP warning, for being verbally abusive.

42. A Supervising Officer (SO) reviewed the man's IEP level. (As a newly convicted prisoner, he was required to complete two weeks on entry level before he could be considered for standard level. His review date was 5 December. If a prisoner receives two IEP warnings, a review must take place within a reasonable timeframe. He had received his second warning on 3 December.) He was not present at the review on 5 December when the SO decided to put him on the basic level, because of his behaviour.
43. Officer A said that, at about 2.00pm, he and Officers B and C went to the man's cell to give him written notice that he was on basic regime and to tell him about the appeal process. They removed his television, because prisoners on the basic regime are not allowed one. Officer A said the man was still abusive, told him to fuck off again and said, "I can ride my basic". As the officers left the cell, he kicked or threw a chair, which hit the door. Officer A worked in reception for the rest of the afternoon and did not see him again.
44. Officer C said he remembered collecting the man's television, but thought it was before lunchtime, which is at 11.45am on Fridays. (There is no closed circuit television on A Wing at Pentonville to check when they removed the television.) He said he remembered the man was not happy about losing his television. He said that he had tried to calm him down and then took the television from the cell.
45. Officer B said they had collected the television sometime before 2.30pm, because the Muslim prisoners returned from Friday prayers at 2.30pm, and they were not back at the time. He said that he stood to the side of the man's door while both officers collected the television. He said he did not remember going back to his cell again while he was on the landing.
46. Prisoner A was in cell A5/35 opposite the man. He said he arrived at Pentonville on 28 November, and had not spoken to him. He said he first became aware of activity in the man's cell when the officers removed his television. He said this was after lunch but before the Muslim prisoners had returned from Friday prayers. After the officers took the television away, he heard the man banging on his door. He said the three officers returned to his cell and opened his door. He could not hear what they were saying because the officers were talking over each other and the man. He said the man's voice was at a higher pitch and described him as "ranting and raving". The three officers left again and Officer B shut the door.
47. The prisoner said that, after the officers left, he saw the light from the man's cell bell go on. (When a prisoner presses his cell bell, a small light goes on outside the cell door on the landing. Staff can cancel the cell bell by pressing a button outside the cell door.) He said the man was also banging on his door and shouting. He saw Officer C walk past the cell and turn the bell off without

looking through the observation panel or speaking to him. He said the man's cell bell light came back on immediately. The officer walked back past his cell and turned the cell bell off again. The cell bell light came on again. The officer returned and stood outside the cell, repeatedly turning the cell bell off as soon as the light came on.

48. The prisoner said the man sounded aggressive and frustrated. He could not hear exactly what he was saying but thought it sounded like he wanted the officer to check something for him. He did not hear Officer C respond. He said that the officer slammed the observation panel in the door so hard that it had sprung back open again. The officer walked away again. Not long after, the officer came back and stood at the door, turning the cell bell off immediately that the man turned it on. He said that he heard the man say, "What are you doing?" and the officer replied, "Shut up". He said the officer had his finger on the button that cancelled the cell bell and continued to turn it off as soon as the man put it back on.
49. The prisoner said that he heard the man say, "I am going to fucking kill myself" and that Officer C had replied, "Do it. If I care." He heard the man say, "You fucking started on me you cunt. You took my fucking TV". Shortly afterwards, the prisoner was let out of his cell to go to the exercise yard.
50. Officer C said he remembered answering the man's cell bell during the afternoon but could not remember how many times. He said that sometimes prisoners press their bells again as soon as the officer finishes talking to them. He said he sometimes stood at cell doors turning the bells off as the prisoner put them on. He said, if he thought that the prisoner was not going to stop pressing the bell, he would walk away and check them later. He said he remembered doing this at the man's cell that afternoon, but did not remember what time this was or how often it had happened.
51. Officer C said he could not remember what the man had said when he answered his bell. He remembered that he was still agitated, as he had been when the officers had removed his television. He said he did not particularly remember him saying he would kill himself and he did not remember replying, "Do it. If I care". He said his usual response to such a statement in such circumstances was to tell the prisoner that he could not begin suicide and self-harm prevention procedures until they actually tried to harm themselves. He acknowledged that sometimes, the manner in which prisoners stated an intention to self-harm was enough to begin suicide and self-harm prevention procedures.
52. Officer C said the man was angry and he thought if he had threatened to kill himself it would have been to get something done, rather than as a serious statement of intent. He did not consider the man intended to harm himself. According to the cell bell log, the cell bell was cancelled at approximately 2.49pm (although the timings do not appear to have been entirely accurate and seem to have been a few minutes behind Greenwich Mean Time). He pressed his bell again at 2.54pm.

53. The man's cell bell record for 5 December shows the following:

Call time	Answer time	Duration
6.06am	6.07am	00:00:17
6.59am	7.02am	00:02:11
7.17am	7.18am	00:00:39
8.28am	8.29am	00:01:06
1.53pm	1.54pm	00:00:24
1.54pm	1.56pm	00:01:34
1.56pm	1.56pm	00:00:12
1.56pm	1.57pm	00:01:07
1.57pm	1.57pm	00:00:00
1.57pm	1.57pm	00:00:01
1.58pm	1.58pm	00:00:10
1.58pm	1.59pm	00:00:45
2.04pm	2.29pm	00:25:32
2.32pm	2.42pm	00:10:49
2.45pm	2.45pm	00:00:08
2.49pm	2.49pm	00:00:46
2.54pm	3.18pm	00:24:07

54. Officer D said he was working in the visits hall on 5 December. During the afternoon, he went to A Wing to tell the prisoner next door to the man that he would not be able to have a visit on Sunday 7 December. He said that as he passed the man's cell on his way off the wing, he noticed the cell bell light was on. At the time, wing staff were busy on A4 landing, the landing directly below, because a prisoner had just fainted. He said he decided to help them out by answering the bell. According to the cell bell log, he cancelled the bell at 3.18pm, 24 minutes after the man pressed it. As noted, we believe that the times recorded on the cell bell log were a few minutes behind Greenwich Mean Time, and that the officer cancelled the bell shortly after 3.20pm.
55. Officer D said he opened the observation panel and simultaneously pressed the button to cancel the bell. He saw the man hanging from the window bars by a sheet. He called for help from staff below, and as soon as they acknowledged him, he opened the cell and went in. He said the man had twisted the sheet to form a sort of rope, which was very hard to cut, but he managed to make a hole using his anti-ligature knife and rip the sheet. Two officers arrived when he was trying to release the man from the ligature. One officer supported the body while he cut through the sheet. The other officer radioed a code one medical emergency (the code used at Pentonville when someone is unconscious or not breathing). She said that she thought that this was at about 3.25pm.
56. A nurse, who was already on A4 landing treating the prisoner who had fainted, went to the cell. Two officers laid the man on the floor and the nurse started cardiopulmonary resuscitation. One officer said the man was still warm. Officer D radioed the control room to confirm that they should call an ambulance.

57. The timings of the radio calls were not recorded, but the officer in the control room called for an ambulance at 3.30pm, rather than immediately the code one emergency was heard. The control room officer asked staff at the scene several times for more information about the nature of the medical emergency, presumably to update the ambulance crew, and was told that the man was in a serious condition. There was some confusion about which prison entrance the ambulance needed to go to and eventually, officers went to both entrances.
58. A GP who was working in the prison that day responded to the emergency call. When he arrived at the cell, he found the nurse performing chest compressions. The nurse had asked for a defibrillator, and it arrived promptly. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.) The GP said that the man was warm, had no pulse and his pupils were fixed and dilated.
59. The nurse continued cardiopulmonary resuscitation. The GP inserted an airway and gave the man oxygen via a bag and mask at a rate of two breaths to 30 compressions. The defibrillator checked him at regular intervals but found no shockable heart rhythm.
60. Two separate sets of paramedics arrived - an ambulance crew followed by the HEMS (helicopter emergency medical team). The London Ambulance Service log records that the first paramedics reached the man at 3.43pm. The HEMS team arrived at the cell at 4.13pm. Before the paramedics arrived, the GP administered a saline solution and then adrenaline via a cannula (a small tube inserted into a vein). Before the first paramedics took over, his heart started beating. By the time the HEMS crew arrived, he had had some cardiac output for about 15 minutes, but he did not breathe unaided at any time. The HEMS team took over emergency treatment when they arrived.
61. At 4.46pm, the man was taken to hospital by ambulance, arriving at 5.06pm. Sadly, he never recovered and died a few days later.

Evidence from other prisoners

62. The man's brother-in-law was also a prisoner at Pentonville when the man arrived. He lived on J Wing, a small unit for prisoners who want to stay drug free, situated on the end of A Wing. He told the investigator that he saw the man shortly after he arrived on A Wing and thought he looked depressed. To help cheer him up, a supervising officer let the man visit him. He said the man wanted to stay on A Wing to be close to him. He said he had encouraged him to get back in touch with his family and break his addiction to drugs. He said the man had talked about spending Christmas with his family and was planning for the future. He had told his brother-in-law that he was going to court on 5 December, and expected to move to HMP Thameside. He said the man seemed quite happy about that.

63. The man's brother-in-law said over the course of the two weeks he spent in Pentonville, the man seemed to settle. He said he had assumed that he had gone to court on 5 December, and was not aware he was in hospital until Monday 8 December, when one of the officers, who knew that they were related, returned to work and told him. He said he had no idea the man was feeling suicidal or he would have offered to share a cell with him. He said he only found out that the man had previously attempted suicide after his death.
64. A prisoner shared a cell with the man between 26 November and 2 December. He said they had got on well. The man told him that he was addicted to drugs and had had a mental breakdown about a year previously. The prisoner said the man was worried about his girlfriend because he had not received a letter she had written to him. He thought that the man wanted to stay in Pentonville until his release, in case the letter came. He said the man talked to himself constantly and was negative about everything. He said that the man used to stand in the corner of the cell mumbling and making hand gestures and sometimes bang his head against the wall or punch it. (There is no record of this in his prison or medical records.) He said that, after a while, he had found this stressful and had asked to move cells, but had not told officers about the man's behaviour.
65. The prisoner said the man was hoping to be released on a drug rehabilitation order. Although he was negative and moody, the prisoner did not think he was suicidal. He said the man had talked about helping his girlfriend get off drugs and starting to help other prisoners through peer mentoring with Phoenix Futures.
66. Another prisoner shared a cell with the man between 2 and 5 December. He described him as a "good guy" and said he talked and laughed a lot. He thought that he seemed to be happy in Pentonville and did not have any obvious problems, although he told him he did not know where his girlfriend was and whether she was in prison or not. The prisoner said that, on 5 December, the man had pressed the cell bell in the morning because his name was not on the list for court. He pressed it a second time for his methadone. Later the same morning an officer told the prisoner to pack because he was moving wings and he did not see the man again. He said the man was very angry that he had not gone to court, but did not think he was suicidal. He said the man used to tie a sheet to the window bars so that he could pull himself up to see out of the high window. Earlier in the week, the prisoner had joked that it looked like the man was about to hang himself and they had laughed.
67. The prisoner who lived in the cell next door to the man was at Friday prayers and did not have any relevant information about him or the afternoon of 5 December. The prisoner in the other cell next to the man did not want to speak to the investigator.

Contact with the man's family

68. The man had not given any details of his next of kin or an emergency contact when he arrived at Pentonville. None of the officers on duty between 5 and 8 December knew that a prisoner was related to him. No one checked other parts of his prison records for details of his family, although his prison telephone account contained contact telephone numbers for his mother, three sisters, solicitor, nephew and two friends. Instead, the prison asked the police to help them locate his family.
69. On Sunday 7 December, police traced the man's family and told them that he was in hospital. The prison's family liaison officer spoke to them on 8 December, met them at the hospital and maintained contact with them after the man's death. The family were with him when he died. The prison contributed to the costs of the funeral in line with national guidance.

Support for prisoners and staff

70. After the man was taken to hospital, the Head of Residence held a debrief for the staff involved in the emergency response, including the healthcare staff, to ensure they had the opportunity to discuss any issues arising, and to offer support. Staff told the investigator they had received appropriate support from the prison.
71. On 5 December, an officer told the man's ex-cellmates that he was in hospital in intensive care and reminded them of available support. The officer returned to duty on J Wing on 8 December, and remembered that the man and another prisoner were related. He told the man's brother-in-law and arranged for a prison chaplain to visit him. On 9 December, the prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by the death.

FINDINGS

Assessing the risk of suicide and self-harm

72. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody) lists a number of risk factors and potential triggers for suicide and self-harm. The man had some factors which increased his risk including, previous attempted suicide, personality disorder, opiate dependency, relationship problems and upcoming court appearances.
73. The man gave inconsistent accounts to the police and prison staff in response to questions about his history of suicide and self-harm. He told the police he had headbutted a wall. He told an officer at High Down he had taken an overdose six months previously, but denied any history of suicide and self-harm at his initial health assessment. At Pentonville, he told a nurse that he had no history of mental illness and no history of suicide and self-harm.
74. There was some limited information about his diagnosis of personality disorder and previous attempts at suicide in his prison medical record and his community medical notes received at Thameside in June 2014. However, this was not flagged and none of the staff who assessed the man at Pentonville had read them. Pentonville asked for his community medical notes on 26 November, but had not received them before he died. His most recent escort record did not note his previous suicide attempts. There was no suicide or self-harm marker on his prison record, only a marker that he had been managed under ACCT procedures in November/December 2013. He did not tell staff about his relationship problems.
75. A case manager had the most in depth conversations with the man during his time at Pentonville. Although he appeared stressed on 2 December, he did not give her any cause for concern and she did not consider him at risk of suicide or self-harm. She offered him an opportunity to talk to her in private but he said he did not want to. The man's brother-in-law spoke to him on several occasions and thought that he seemed positive about the future and getting back in touch with his family. He did not know about his previous suicide attempts until after he died.
76. Officer C said he did not particularly remember the man saying he was going to kill himself on 5 December, although he accepted he might have done. He said that the man was angry and he thought that he might have threatened to kill himself to spur him into doing something for him. He said that, in the heat of the moment, it was not unusual for prisoners to say things, such as they would kill themselves, and he used his experience to decide whether they meant it or not. He appeared confused about the circumstances in which he would open an ACCT, but he did not think the man intended to kill himself. We accept that in such circumstances staff have to use their own judgement. Although his volatile behaviour should have prompted some concern, without

further knowledge of him it is unlikely that anyone would have immediately identified that he was at risk of suicide and self-harm.

77. Although it is a concern that staff at Pentonville were not aware of all of the man's risk factors for suicide and self-harm, we recognise that, even had they read all his records, there was little to indicate that his risk was heightened at the time so that he needed to be managed under ACCT suicide and self-harm prevention procedures. None of the staff who saw him considered that he was at risk of suicide and self-harm. We do not consider that the weight of risk factors was sufficiently obvious to conclude that should have outweighed staff perceptions of his mood and demeanour.
78. Nevertheless, PSI 74/2011, about early days in custody, includes a mandatory requirement for reception staff to examine a prisoner's Person Escort Record (PER) and any other available documents, and interview the prisoner to assess the risk of suicide and self-harm. While we accept that the information was not easily accessible, there was some limited information about the man's risk in his prison and medical records, which staff did not read and consider. We are also concerned that Officer C appeared to consider that a prisoner would need to harm himself, rather than just making threats, before he would begin ACCT procedures. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff consider all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from prison and medical records and other documents and that staff understand the circumstances when they should consider opening an ACCT, including when a prisoner has expressed suicidal intent.

Response to the man's cell bell

79. Officer C said that he did not remember the sequence of events on 5 December, or recall how many times he had answered the man's cell bell. He said that he sometimes stood at cell doors turning off cell bells as the prisoner put them on and if he decided the prisoner was not going to stop pressing the bell, he walked away and checked them later. The cell bells are intended for emergency use only and we recognise that the man's behaviour was challenging and might have been seen as manipulative. Nevertheless, prison officers must deal appropriately with challenging prisoners.
80. The man was clearly very agitated on 5 December. He was upset that he had been put on basic regime, and his cellmate said he was angry that he had not gone to court. Officer C's response was unlikely to have calmed him down and there is no evidence that he tried to do so. Even if he felt that the man was not at risk of harming himself, he should have tried to identify and address the cause of his distress. We believe that the officer should have done more to de-escalate the situation. If he felt unable to deal with his behaviour, or he did not think that he would respond to him, he ought to have considered asking another member of staff to speak to him.

81. Because there is no CCTV on A Wing, and in the absence of information from officers themselves, we cannot know for certain, who answered which bell and we do not what time the prisoner opposite the man's cell went out to the exercise yard. We do know that the man rang his bell eight times between 1.53pm and 1.58pm. Each time – apart from two occasions when it took a minute – they were cancelled within seconds. Between 2.04pm and 2.49pm, he rang the bell four more times – the first two took over 25 minutes and over ten minutes to respond to which was far too long. The latter two were answered almost immediately. However, the 2.54pm bell was ignored by wing staff and answered at 3.18pm only because a visits officer happened to be passing by. This was a delay of over 24 minutes, which is unacceptably long.
82. Her Majesty's Inspector of Prisons has an expectation that cell bells should be answered within five minutes and this is the standard we expect. Inspectors have noted at successive inspections that staff at Pentonville do not respond to cell bells as they should. The man hanged himself during the 24 minutes it took to answer his last cell bell. Had staff answered the bell within an acceptable period, they might have been able to save his life. We recommend that:

The Governor should ensure that all cell bells are answered within five minutes and that when prisoners ring their bells repeatedly, staff make active attempts to engage with them to de-escalate the situation and address the underlying cause.

Emergency response

83. In our investigations into two deaths at Pentonville in April 2013 and June 2014, we made the same recommendation that the local emergency response policy should reflect the requirements of Prison Service Instruction 03/2013, and that the control room should call an ambulance immediately an emergency code is called. This issue had also arisen in deaths before April 2013, and the prison had promised to take immediate action. Yet it appears this recommendation had still not been acted on in December 2014, when the man died. Although an officer radioed a code one emergency, the control room officer did not call an ambulance immediately.
84. There is no evidence that the delay affected the outcome for the man, as the resuscitation attempt was prompt and competent. However, in such cases, every second can be crucial to the success or failure of resuscitation. There continued to be confusion about which entrance the ambulance should be directed to, a matter we have also raised in previous investigations.
85. Since the man's death, the senior manager responsible for safer custody at Pentonville has agreed a protocol with the London Ambulance Service and updated the local policy to instruct staff to call an ambulance immediately an emergency code is called. She told the investigator that the recording of the emergency radio message in this case will be used to train staff and embed

the local policy. During the most recent inspection of Pentonville, inspectors noted that ambulances were called promptly in two emergency responses they witnessed. We are satisfied that the prison has now responded appropriately and therefore make no recommendation.

Informing the man's family

86. Prison Rule 22 requires governors to inform the prisoner's next of kin "at once" when a prisoner becomes seriously ill or sustains any injury. Prison Service Instruction (PSI) 64/2011 also details the procedures to follow when a prisoner suffers sudden life threatening harm. The prison must contact the next of kin or a nominated person and give them an accurate account of what has happened, whether the prisoner is in hospital, and information about visiting the prisoner. When a prisoner has no recorded next-of-kin, reasonable steps must be taken to trace any family, including liaising with the police, contacting the prisoner's solicitor, checking with other prisoners and reviewing prisoner's records for visits, letters, and phone calls.
87. The man did not give details of his next of kin or emergency contact when he arrived at High Down or Pentonville. After he was taken to hospital on 5 December, the prison asked the police to trace his family, but this took two days. The prison appointed a family liaison officer on 8 December, and he informed the family that day. However, the telephone numbers for his mother, three sisters, solicitor, nephew and two friends were all on the list of approved numbers on his prison telephone account. There is no evidence that the prison checked his records and as his family's telephone numbers were readily accessible, we consider the delay in contacting them was unacceptable. We recommend that:

The Governor should ensure that prisoners' families are informed as soon as possible when prisoners are seriously ill in hospital and that staff check all sources of information when there is no recorded next of kin.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that staff consider all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from prison and medical records and other documents and that staff understand the circumstances when they should consider opening an ACCT, including when a prisoner has expressed suicidal intent.	Accepted	The local ACCT training reinforces the need for staff to consider all known risks and use all available information to determine a newly arrived prisoner's risk of suicide and self-harm, and when staff should consider opening an ACCT. ACCT training is delivered to all new staff (operational and non-operational)staff and refresher training is delivered to groups of staff bi-monthly Healthcare staff will be reminded of the need to ensure that all information (e.g. contained within warrants/prisoner escort records) that arrives with new prisoners in Reception is reviewed for concerns. Where any risks / triggers are identified, Healthcare staff will be reminded of the need to ensure that a prisoner's whole previous healthcare record is reviewed during the 'Wellman' Clinic which takes place the following day. Healthcare reception processes will be delivered in training sessions quarterly.	Head of Healthcare Head of Residence Head of Safer Prisons and Equality December 2015	
2	The Governor should ensure that all cell bells are answered within five minutes and that when prisoners ring their bells repeatedly, staff make active attempts to engage with them to de-escalate the situation and address the underlying cause.	Accepted	It is expected that all cell bells will be answered within 5 minutes. This answering of cell bells will be monitored by managers on a monthly basis to ensure compliance. Staff Information Notices will be issued to reinforce this expectation and to also remind staff of the need to make proper enquiry and attempt to de-escalate the situation when a prisoner repeatedly presses the cell bell and where there is no immediate sign of emergency.	Head of Residence August 2015	
3	The Governor should ensure that prisoners' families are informed as soon as possible when prisoners are seriously ill in hospital and that staff check all	Accepted	All Governors and Custodial Managers will be briefed via email and verbally briefed on the need to check all available sources for family contact when a prisoner is seriously unwell and that Family Liaison	Head of Safer Prisons and Equality	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	sources of information when there is no recorded next of kin.		Officers are appointed at the earliest opportunity and ensure that next of kin are contacted promptly.	July 2015	