Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Pentonville, in October 2014

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

This is the investigation report into the death of a man, who died at HMP Pentonville in October 2014. He choked and died while being searched when he tried to conceal a package he had apparently received during a visit. He was 30 years old. I offer my condolences to his family and friends.

The investigation found that the prison had intelligence that the man might receive a package of drugs from a visitor on the day he died. Plans to ensure that all visitors were checked by a drug dog did not work effectively, as not all visits staff had been informed. Nor were visits staff adequately trained in surveillance techniques.

The man was searched after the visit and officers had to restrain him when he did not comply. I consider that this was appropriate. However, while officers appear to have used recognised techniques, I remain concerned that he was restrained face down with an object in his mouth and an officer used pain compliance in an effort to persuade him to give it up. The risks in using these techniques in these circumstances do not appear to have been fully understood, nor adequately set out in policy. There is a need for better national guidance about the risk of restraining prisoners, and using pain compliance techniques, when breathing is already compromised by having concealed a package in their mouth.

I am satisfied that officers ended the restraint and began appropriate emergency procedures as soon as they realised there was a problem, although there is a need to improve liaison with the ambulance service to avoid unnecessary delay in accessing the prison.

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 **March 2016**

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Summary

Events

1. In July 2014, the man was remanded to HMP Pentonville after being charged with robbery. He had a history of substance misuse and had served a number of prison sentences before. It was just a month since he had been released from a previous sentence at Pentonville.

2. When the man arrived at Pentonville he told healthcare staff he had no major health problems, but was suffering from symptoms of drug withdrawal. He had been prescribed buprenorphine in the community to help manage his dependence on heroin and mirtazapine for depression. Doctors continued his prescriptions in prison.

3. While the man was at Pentonville staff suspected him of smoking cannabis three times. However, they did not carry out drug tests or search him or his cell.

4. In October, a prison officer received information that a friend, who was visiting the man that day, would be passing him a package of drugs. The officer in charge of visits arranged for all visitors to pass a drug-detection dog on their way into the visits hall. Staff who were searching visitors were unaware of this. His visitor arrived on crutches and, after a brief search, they took her to the visits hall by a lift, rather than the usual route. This meant that she did not go past the drug dog.

5. When visits staff realised that the man's visitor had avoided the drug dog, they decided to search him after the visit and two prison officers took him to the search area. As they began to search him, he tried to put his hand in his underwear, apparently trying to retrieve something. One of the officers said they would restrain him if he did that again. When he did, the officers activated a general alarm for help and tried to restrain him, but he resisted and the officers and he fell to the floor. Other officers arrived and saw that he had a package in his hand, which he put in his mouth. They told him to spit it out, and used pain compliance techniques, but he continued to resist. When they tried to stand him up, he stopped resisting and went limp. One of the officers realised that something was seriously wrong. They released their holds and lowered him to the floor.

6. An officer radioed for a nurse and shortly afterwards another officer radioed a medical emergency code. As a result, a control room officer called an ambulance.

7. The man had lost consciousness and prison officers tried to dislodge the package from his throat using recognised procedures for chocking. Nurses took over, but could not dislodge the blockage. Ambulance staff managed to remove the package from his throat, but were unable to revive him. An emergency service doctor declared him dead.

Findings

8. The investigation found that, although staff suspected several times that the man was smoking cannabis, they did not test him for drugs or search his cell.

9. In October, searching staff were unaware of the need for all visitors to pass by the drug-detection dogs. Staff did not use camera surveillance in the visits hall. We consider that all the relevant staff should be appropriately briefed about potential security risks in visits and targeted surveillance should be used when necessary.

10. The officers who searched the man appear to have used recognised techniques to try to prevent him hiding the package. Restraining prisoners in a prone (face down) position increases the risk of positional asphyxia and the fact that he had an item hidden in his mouth must have increased this risk. We are concerned that there is little national guidance about the risks in such situations including the use of pain control techniques when a prisoner has an item concealed in his mouth. As soon as officers realised that he was unresponsive, they stopped restraining him, called for medical help and used appropriate first aid techniques to try to prevent him choking.

11. The officer who called the ambulance told the ambulance service which gate to go to but, as in a number of other cases at Pentonville, there was some confusion, which resulted in a slight delay in reaching the man.

12. When the man died, there was a delay before staff from Pentonville informed his family because the police wanted to complete their investigations first. We are satisfied that this was not within the prison's control.

Recommendations

- The Governor should ensure that there is an active response to security intelligence, as part of an effective drug supply reduction strategy.
- The Governor should ensure that when there is specific intelligence that contraband might be passed during a visit, all relevant staff are sufficiently briefed to allow an effective coordinated response and that staff are trained and able to use directed surveillance equipment when the circumstances justify it.
- The Chief Executive of NOMS should ensure that there is clear guidance and training on the safe use of force, including pain-compliance techniques, when resistant prisoners have items in their mouths, which might compromise their breathing.
- The Governor and Head of Healthcare should ensure that there is a protocol with the London Ambulance Service, which sets out clear arrangements for ambulances arriving at Pentonville to avoid any delay and that ambulance staff have quick access to prisoners in an emergency.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

14. The investigator and a colleague visited Pentonville on 6 November 2014 and met the Governor and a member of the Independent Monitoring Board. They visited the man's cell, the visits hall and search area and obtained copies of relevant extracts from the man's prison and medical records.

15. The Metropolitan Police shared statements they had taken from prison staff with the investigator. He interviewed five members of staff at Pentonville on 5 and 19 June 2015.

16. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

17. The Metropolitan Police investigated the circumstances of the man's death and the investigator kept in contact with the officer in charge during the investigation. In line with our terms of reference, we suspended our investigation for 25 weeks while the police carried out their investigation. We regret the delay this has caused in issuing this report.

18. We informed HM Coroner for Inner North London District of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation and invite her to identify issues she and her family would like the investigation to consider. She said that they had been upset at the delay in the prison breaking the news of her brother's death to them.

20. The man's family received a copy of the initial report. The solicitor representing them confirmed that they did not wish to make any comments on the report. NOMS received a copy of the initial report.

Background Information

HMP Pentonville

21. HMP Pentonville is a local prison serving the courts of North London and holds over 1,300 men. At the time of the man's death, Whittington Health, Camden & Islington NHS Foundation Trust, and Barnet, Enfield and Haringey NHS Mental Health Trust provided health services, including substance misuse, mental health and psychiatric care.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons most recently inspected Pentonville in February 2015. Inspectors noted that illicit drugs were easily available in the prison, but too few prisoners were tested for drug use, either by random or suspicion testing. Care for prisoners with drug and alcohol problems was good. Management of intelligence was reasonably good, but some elements of dynamic security were weak, and requests for targeted searches were sometimes not acted upon quickly enough. There was no detailed drug supply reduction strategy. Inspectors noted that visitors were searched respectfully and that prison staff showed a compassionate approach to visitors. Healthcare staff responded to emergency calls quickly and professionally and an ambulance was called promptly in emergencies.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its annual report for the year to 31 March 2014, the IMB wrote that funding reductions had meant that local management and frontline staff had struggled to cope with lower staffing levels. The IMB noted that it was generally acknowledged that visits were a common way of bringing small quantities of drugs into the prison but security measure appeared less stringent since new working procedures had been introduced. Regular drug testing had been affected by reductions in staffing levels.

Previous deaths at HMP Pentonville

24. Between the end of 2011 and the man's death, we investigated seven deaths at Pentonville. There has since been one further death. Of these, three were the result of natural causes; five were self-inflicted. We have previously identified a delay in informing a prisoner's family of his death and in making sure ambulance staff reach prisoners for emergency treatments as quickly as possible.

Pentonville's searching policy

25. Pentonville's policy is that all visitors will have a level A search when they enter the prison. This means a rub-down search and searches of shoes, pockets, and hair, and looking into the visitor's mouth. A drug-detection dog is used frequently to screen visitors to detect the presence of illegal drugs.

26. The National Offender Management Service uses drug-detection dogs as part of the strategy to prevent illicit drug use in prison. The dogs are trained to detect certain types of illicit drugs, including during searches of visitors.

27. The prison's local security strategy states that, after visits, staff will conduct a full search (strip search) of one in ten prisoners picked at random. If there is specific intelligence about a prisoner that suggests he might have unauthorised items, staff will conduct a full search. Prisoners should first be asked if they have any unauthorised items they should not have and asked to hand them over.

28. During a strip search, two officers are present and the prisoner is asked to remove his clothes from the top half of his body. An officer examines them while the other officer observes the prisoner's body to see if anything is concealed. The prisoner's clothes are then returned to him and the procedure is repeated for the lower half of the body. If something is found during a search, staff must ask the prisoner to hand the item over and guard against the prisoner trying to dispose of it, such as by swallowing or throwing it away. Reasonable force can be used to ensure that prisoners comply with searches.

Key Events

29. The man was remanded to Pentonville on 15 July 2014, after being charged with robbery. He had been in prison before, and had been released from Pentonville just the month before. Records show that he had a history of substance misuse and had been supported by drug workers in prison before. On 1 February 2013, during a previous sentence at HMP Thameside, he had taken an unauthorised package from a visitor. When prison officers intervened, he assaulted one of them and he was removed from the visits hall by force.

30. At an initial health screen at Pentonville, the man said he had no concerns about his physical health. He told the nurse that he had a history of drug use, including heroin and crack cocaine, and that he was prescribed mirtazapine (an antidepressant) and buprenorphine (to treat opiate dependence). A substance misuse nurse confirmed with his GP that he was prescribed an antidepressant and10mg of buprenorphine daily, with the support of a community drug team. The nurse referred him to the Integrated Drug Treatment Service. (IDTS is designed to provide a joined-up approach for prisoners with drug problems and meet their clinical and psychosocial needs.)

31. Staff allocated the man to F Wing, for prisoners needing treatment for substance misuse. He continued to be prescribed buprenorphine, with occasional adjustments to the dose, throughout his time at Pentonville and was supported by substance misuse services.

32. On 21 August, staff reported to the security department that there was a smell of cannabis coming from the cell the man shared with another prisoner. On 23 September, prison staff again noticed a strong smell of herbal cannabis coming from the cell. An officer noted in the man's prison record that both he and his cellmate appeared to be under the influence of some kind of drug. He submitted an intelligence report, which noted that the man and his cellmate had been caught swallowing an unknown substance the previous Friday. There is no reference in his records to this incident. On 11 October, an officer noted in the man's record that there was a strong smell of cannabis coming from his cell and submitted an intelligence report. There is no record of any action being taken in response to these reports.

Day of the Incident

33. In October, the man had a visit booked. At 11.00am, a Supervising Officer (SO) told SO A, who was in charge of visits that day, that a prisoner had informed him that the man's visitor might attempt to pass him something during the visit. The SO spoke to SO B, who was responsible for the prison's drug-detection dogs, and they agreed to use a dog to check all visitors that afternoon. SO A was satisfied that the use of a dog and a standard rub-down search for all visitors was sufficient response to the intelligence. He did not alert others in the security department, or tell other members of the visits team.

34. At 2.00pm, visitors began to arrive. Two operational support grade (OSG) staff searched visitors. Nobody had told them there were suspicions about the man's visitor. OSG A told the police that staff give all visitors a level B search, which involves a full rubdown, looking into the visitor's mouth, and asking them to

remove their shoes. Visitors then went through a separate room, past the drug-detection dog, before staff escorted them up a flight of stairs to the visits hall.

35. CCTV footage shows that the man's visitor arrived in the search area at 2.12pm. She was using crutches. OSG A recognised her from previous visits, when she had also sometimes used crutches. OSG B also remembered her arriving on crutches on previous visits. They both said that she appeared to be in pain and had told them that she had damaged her back in a car accident. OSG B offered her the use of a lift to the visits hall to avoid having to climb the stairs. She telephoned the visits hall and asked SO A if someone could come and take a visitor to the visits hall in the lift. OSG A searched the visitor. In her statement for the police, she said that this was difficult, as she was on crutches. CCTV footage shows that she searched the visitor's rib and hip areas. She looked into her shoes but did not search her back or the crutches. She said that because of the visitor's mobility problems, she did not ask her to go through the room with the drug dog. She did not tell the dog handlers.

36. Officer A came to collect the visitor from the search area. OSG A did not tell him that she had not been past the drug dog and the officer took her to the visits hall in the lift.

37. At 2.50pm, SO B, who was with the drug dog, phoned SO A and said that he had not seen any visitors for the man. SO A said that his visitor was with him. He decided that rather than interrupting the visit and possibly causing a disturbance, he would ensure the man was strip searched when he left the visits hall. He asked two officers to watch for any sign of the visitor passing anything to him during the rest of the visit. They did not see anything.

38. The visits session ended at 4.00pm and SO A asked both officers to search the man before any other prisoners. They took him into the search area, which is a room off the main visits hall, with a waiting room on one side, and a toilet on the other. For privacy, there is no CCTV coverage of the search area, which is screened from view. Prisoners stand on a mat in the centre of the room during the search.

39. Officer B said that he explained the purpose of the search to the man and asked him if he had anything in his possession that he should not have. He said he did not. He asked him to remove his jacket and T-shirt, which the officers then searched. He returned them to him and then asked him to remove his shoes and his socks, which the officers then searched. They did not find anything.

40. Officer B then asked the man to remove his trousers. He said that, at this point, the man became more edgy. He searched the trousers and found nothing. The officers noticed that the man was wearing more than one pair of boxer shorts, which made them suspicious. They said that he appeared to be getting nervous and was trying to move off the search mat. He took off one pair of boxer shorts and handed them to the officers. As they were examining them, he tried to put his hands down the boxer shorts he was still wearing. Officer B told him to keep his hands by his sides, and he did so. He then asked him again if he had any unauthorised items, and again he said he did not.

41. Officer B asked the man to take off the next pair of boxer shorts, and told him that if he made any sudden movements or attempted to remove anything from his boxer shorts, they would restrain him. He then again put his hand inside the boxer shorts, which he was still wearing. The officer grabbed his head and pulled him towards him and Officer A took his left arm. Officer B then grabbed his right arm. He resisted and, as the officer moved to hold his right arm, they fell to the floor. As they did so, the officer pressed the general alarm button. The prison's radio log shows that this was 4.05pm. The officer saw a package in his hand and said "it's in his hand". (The package was later measured and found to be three inches by one inch. We understand that it contained drugs and blank memory cards.)

42. Other staff arrived in response to the alarm. Officer C told the police that he heard one of the officers say, "Let go of the package". The other two officers were trying to hold the man's arms so, in line with Prison Service control and restraint techniques, Officer C took control of his head. Officer A asked Officer D to take control of his left arm and he moved to control the legs. The man was kicking and struggling, and Officer D said that he had a package in his right hand. Officer C said one of the officers again told the man to let go of the package, but he managed to free his right arm from Officer B's grip and put the package into his mouth. At this point, he was restrained face down on the floor.

43. The officers told the man to spit the package out but he continued to struggle. Officer C said that he told him several times to spit the package out, or he would use pain compliance (a technique that causes pain but no long-term injury). When the man did not comply he used a pain compliance technique, known as the mandibular angle technique, in which he had been trained. He used the technique again, and again asked him to spit the package out, but he continued to struggle.

44. Officer C decided that they should move the man to the segregation unit. He asked all the officers restraining him if they had control of the areas they were holding, and they confirmed that they had. The next stage was to stand him up. A SO and Officer C told him to bring his knees up to his chest. He did not do so and Officer C assumed that this was a further act of non-compliance. The officers lifted him to his knees, and Officer B noticed that he had gone limp and his face was blue. He said, "He's not responding. I'm calling a medical emergency". The staff lowered him back to the floor and released their restraint locks. SO A radioed for medical assistance, but another SO immediately radioed a level one medical emergency (this was at 4.09pm) and said that they needed an ambulance. The control room operator radioed the prison's emergency response nurse and then, after clarifying some basic details with staff in the search area, called for an ambulance at 4.10pm. He asked the ambulance service to go to the prison's Roman Way gate.

45. The officers thought that the man had tried to swallow the package. Officer D immediately began to perform chest compressions, but he remained unresponsive. An officer moved behind the man and performed abdominal thrusts to try to dislodge the blockage, but without success. Officers then moved him to the recovery position. Officer D tried to dislodge the package by hitting him on the back, but was unable to do so.

46. The emergency response nurse that day arrived as Officer D was putting the man into the recovery position. The staff told her that he had swallowed a package. He was unresponsive, had vomited, had no pulse, and had a swelling in his lower neck. She asked Officer D to thump his back again to try to dislodge the blockage. Again, this was unsuccessful. Other healthcare staff arrived. Another nurse detected a weak pulse, but the man was still not breathing. The nurses tried to resuscitate him using emergency equipment. While they were performing cardiopulmonary resuscitation he vomited again, but they could not move the blockage in his throat.

47. The ambulance service's first response vehicle arrived at 4.17pm, but arrived at the prison's North Wall gate, which was locked and unattended. The vehicle then went to the Roman Way gate, arriving less than two minutes later. An ambulance also arrived. Ambulance service staff said in their statements that there were short delays getting into the prison because of security checks before prison staff escorted them to the search area. They then took over the man's emergency treatment. More paramedics and a doctor arrived and joined in the efforts to save him. They managed to remove the blockage from his throat, but were unable to revive him. At 4.54pm, the doctor declared his death.

Contact with the man's family

48. Two family liaison officers were appointed. One said that police took control and told him they wanted to accompany him to inform the man's family of his death, but first needed to make some enquiries into the apparent smuggling of the package into the prison. This took some hours. They went via a police station and the police decided to arrest the man's visitor first. On the way, they were further delayed by a traffic accident they witnessed. It was not until 4.30am the next day that the family liaison officer and the police arrived at the family's home and informed the man's mother of his death. The family liaison officer offered condolences and support.

49. In line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

50. Managers debriefed the staff involved in the emergency and the staff care team offered support. Managers also called the Prison Service's national trauma team for advice. Staff checked prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by the news of the man's death. Staff gave the man's cellmate extra support.

Police investigation report

51. The Metropolitan Police investigated the circumstances surrounding the man's death. At the time of our initial report, the Crown Prosecution Service had not made a decision on any criminal action.

Post-mortem report

52. The post-mortem examination concluded that the man died as a result of acute respiratory failure consistent with obstruction of the upper airway.

Findings

Clinical care

53. The man received appropriate health screenings when he arrived in Pentonville. Staff noted his substance use, and prescribed appropriate medication, which they kept under review during his time there. He did not have any other health needs, and the clinical reviewer noted that the man had a standard of care at the prison equivalent to that he could have expected to receive in the community.

54. Officers tried to help move the blockage by using abdominal thrusts (also known as the Heimlich manoeuvre) and hitting the man's back, but were unable to do so. The clinical reviewer noted that these procedures were in line with the Resuscitation Council guidelines for chocking. Nurses also tried these procedures and began cardiopulmonary resuscitation in accordance with the Resuscitation Council's guidelines for the management of a severe airway obstruction in an unconscious patient. Attempts to administer oxygen were unsuccessful because of his blocked airway.

55. The clinical reviewer said that paramedics retrieved the package from the man using a laryngoscope (a hinged instrument which allows the viewer to see into the throat) and Magill forceps (a long, hinged instrument). This was a procedure that required specialist training, experience and equipment. We are satisfied the emergency response was appropriate.

Response to submissions of drug use

56. There were three occasions, in August, September and in October, when officers suspected that the man was smoking cannabis. When this was noted in September, there was also a reference to him having been caught swallowing an unknown substance, but there are no other references to this in his records. Officers submitted intelligence reports, but there is no record on any action being taken. He did not have a drug test and there was no cell search. In a note on his prison record on 28 October, one of the prison officers commented that he doubted he would have to take a drug test as the officers responsible for testing were regularly redeployed to other duties.

57. The Head of Security told the investigator that there had not always been enough trained officers to cover searching and drug testing. During the inspection in February 2015, HM Inspectorate of Prisons found that too few prisoners were being tested. We are concerned that no action was taken when evident security risks were identified. While this was not directly related to the immediate circumstances of the man's death in October, the lack of effective action or sanctions when drug taking is detected or suspected can only encourage prisoners to continue to attempt to smuggle illegal drugs into the prison.

58. In June 2015, the Head of Security told us that all prisoners suspected of using illegal substances are now searched and tested. We consider it is important to maintain that position and make the following recommendation:

    The Governor should ensure that there is an active response to security intelligence, as part of an effective drug supply reduction strategy.

Management of intelligence in October

59. Pentonville does not have specific procedures for responding to intelligence about smuggling during visits. Officers usually pass intelligence to the security department, which then collates the information and co-ordinates the response.

60. When a SO received information at around 11.00am that the man might receive some contraband during a visit, he took the information to SO A, who was in charge of visits, and SO B, who was responsible for the drug dogs. He submitted an intelligence report (IR), although he did not do so until 2.15pm, by which time visits for that day were already underway. He marked the security threat as 'medium'. The guidance for submitting security reports says that, unless there is a threat to the security of the prison:

> "… intelligence can be successfully managed by developing counteracting strategy proportionate to risk and timescale. For example, if an IR details intelligence received in the morning concerning a visit that afternoon, the [analyst] needs to evaluate the IR and examine supporting intelligence. The Security Manager and Governor then need to specify what counter action is to be taken in sufficient time. Therefore, in this case, the IR Security Threat Impact level would be appropriately assessed as Medium and processed within 24 hours."

61. When the SO received intelligence that an unauthorised article might be coming into the prison, his first priority was to ensure that staff addressed the threat quickly. He did so by informing the drug-dog team and the manager in charge of visits. He submitted an intelligence report, but did not do so until visits were underway. His intelligence was that something might come into the prison either that day or in the next 48 hours. The security department therefore did not have the opportunity to analyse the intelligence and co-ordinate a response for that afternoon's visits. We consider that the SO addressed the issue appropriately and his actions did not contradict the intelligence report guidance.

62. SO A said that he had not been given intelligence information in this way before and SO B also said that it was unusual for intelligence to come to him directly by telephone. Nevertheless, both were confident that they could address the issue that day.

63. As the officer in charge of visits, SO A was satisfied that having all visitors checked by a drug dog that afternoon, was sufficient response to the intelligence. He said that he did not share the intelligence with the staff conducting searches on visitors as intelligence is usually shared with as few people as possible. He expected staff to search all visitors coming into the prison, as they would normally do. Unfortunately, because the man's visitor used crutches, she bypassed the drug-detection dogs, as the staff gave what they considered was appropriate help to an injured and disabled visitor. We are satisfied that the plan to address the intelligence was appropriate and accept that these circumstances were not foreseen. We understand why managers might not want to divulge

specific information about the individual targets but to avoid this happening in future we consider that they should ensure that searching staff understand the importance of all visitors having the same search arrangements.

64. Prison staff can apply for directed surveillance authorisation during a visit if they have specific intelligence and it might assist maintaining the prison's security. Using special cameras, a prison officer can closely watch the prisoner and his visitor(s). We were surprised that, as there was specific information that the man might receive a package from his visitor, this was not considered. SO A said he did not apply for authorisation for directed surveillance because he said that neither he nor his staff knew how to use the equipment. The Head of Security told the investigator that, in the six months since she had been at Pentonville, she had not been asked for authority to use directed surveillance, in contrast to her experience in other prisons. We make the following recommendation:

The Governor should ensure that when there is specific intelligence that contraband might be passed during a visit, all relevant staff are sufficiently briefed to allow an effective coordinated response and that staff are trained and able to use directed surveillance equipment when the circumstances justify it.

Searching, control and restraint and pain compliance

65. Pentonville told the investigator that all the officers who used restraint techniques on the man had undergone appropriate control and restraint training and their training was in date. The visits search area is not covered by CCTV, which has made it difficult to be certain about the exact events in October when he was being searched and restrained. However, there were a number of staff present after the officers rang the alarm bell for help and the police were satisfied that the accounts provided by prison staff who were involved with or who had witnessed his restraint were consistent. None of the staff who witnessed the officers restraining him were concerned about the techniques used. All the staff present said that, as soon as it became clear that there was a problem, officers immediately released him. We have examined the use of force statements and the statement to the police and consider there is no reason to doubt that they are credible accounts of the events on the day of the incident.

66. Officers A and B seem to have conducted the search carefully, although not quite in line with the procedures in Prison Service Instruction 67/2011, Searching the Person. The PSI says that the prisoner should be asked to remove his trousers and underpants together, which should then be passed to the second officer to search, while the lead officer, (in this case, Officer B) observes the prisoner's body and the area around him in case he has dropped anything. The officers searched the man's trousers separately and then one set of boxer shorts, before he had removed the other clothing from his lower body, possibly as a result of prevarication on his part. This was a problem, as it is evident that he had concealed the package in his underwear and appears to have been wearing two sets of boxer shorts plus an additional set of underpants.

67. It might have been more effective to have required the man to remove his trousers and all his underwear before beginning to search them. This would

have made it more difficult for him to try to conceal the package. However, the officers were in a difficult position; they were apprehensive and trying to control the situation carefully. They strongly suspected he had an item concealed and warned him that they would restrain him if he made any sudden movement or attempted to retrieve an item from his underwear. When he did, they tried to restrain him by the arms, but he resisted and they fell to floor. We are satisfied that this initial use of force was a reasonable response.

68. When other officers responded to the alarm bell and found the man struggling on the floor with Officers A and B trying to control him, we are satisfied that they used approved Prison Service control and restraints techniques and this initial use of force was also reasonable in the circumstances. As officers were restraining him, he managed to put the package in his mouth. He continued to struggle and refused to spit the article out of mouth. At this stage, he was being restrained in a prone, face down, position, which is known to increase the risk of positional asphyxia. The fact that he had an item hidden in his mouth must have increased this risk and the risk of choking. However, there is little evidence that this additional risk was taken into account.

69. In an unsuccessful attempt to get the man to expel the object from his mouth, Officer C twice used the mandibular angle technique, which is a recognised pain compliance technique. This involves placing pressure on a nerve near the angle of the jaw. For any use of force to be justified, it has to be reasonable in the circumstances, necessary, no more force than is necessary should be used, and it should be proportionate to the seriousness of the circumstances. While we do not doubt the officer's objective in trying to get the man to give up the package, it is not clear whether the primary aim was safety or compliance. We are less sure that this additional use of further force through pain compliance was necessary and fully justified. We have serious concerns about whether it is an appropriate technique to use in a situation when a prisoner is being restrained in a prone position with an object in his mouth. We cannot discount the possibility that an involuntary physiological response to the pain applied could cause someone to swallow and ingest an item carried in their mouth, with a consequent risk of choking.

70. The Government's Independent Advisory Panel on Non-Compliance Management judged the mandibular angle technique to be a safe technique in its report of March 2014, although the report cited a minor risk of compromise to the airway or breathing if the technique was misapplied. The report did not refer to its use in circumstances such as this, where the recipient's breathing was already potentially compromised.

71. We spoke to the Prison Service's National Tactical Response Group, who said that the technique is authorised for use in the prone position, but that there was no guidance on whether it should be used when the recipient has an item in their mouth and this is not covered in training. The advice was that in these circumstances, officers should risk assess whether the technique is appropriate.

72. We are concerned that there is little information, guidance and training about the use of force when someone is a prone position and, in addition, has an object in their mouth, which might compromise their breathing. Nor is there clear

guidance about using the mandibular angle technique in these circumstances. The National Offender Management Service's training manual for the use of force, identifies the risk of positional asphyxia in a prone position but does not refer to incidents when prisoners also have objects in their mouth. This is not an uncommon scenario during searches. The manual notes that when a prisoner is in the prone position, pressure should not be placed on the neck, especially around the angle of the jaw or the windpipe. Such pressure, particularly in the region below the angle of the jaw is dangerous as it can disturb the nervous controls to the heart and lead to a sudden slowing or even stoppage of the heart. There is no reference to the use of the mandibular angle technique in this aspect of the guidance, or whether it should be avoided.

73. We consider that the circumstances of the man's death have illustrated the need for appropriate guidance and training for the safe use of force when prisoners have objects in their mouths, which might compromise their breathing. The National Offender Management Service (NOMS) also needs to be assured that use of the mandibular angle and other pain compliance techniques are safe to use when a prisoner's breathing is already compromised. We make the following recommendation:

The Chief Executive of NOMS should ensure that there is clear guidance and training on the safe use of force, including pain-compliance techniques, when resistant prisoners have items in their mouths, which might compromise their breathing.

Admission of ambulances

74. Pentonville has three different gates, not all of which are in operation at the same time so when an ambulance is required, the ambulance service needs to know which gate to go to. The control room officer asked the ambulance service to direct their vehicles to the Roman Wall gate, but the first response vehicle had already been despatched and went to the North Wall gate, which was not in operation at the time. The vehicle then had to drive round to the Roman Wall gate, which took about 90 seconds.

75. The first response paramedic said that there were delays in getting into the prison because of security checks and the first ambulance crew said that there was a short delay in finding the correct building. They had to contact their control centre and ask for someone to come and meet them. The second ambulance also had difficulty getting into the prison.

76. In an emergency, any delay can make a difference. We made a recommendation about this issue after a death at Pentonville in 2009, when an ambulance went to the wrong gate. This was also a problem in another recent death at the prison. Although the officer in the man's case told the ambulance service the correct gate to go to, there still appears to be some confusion and difficulty in communication, which the Governor needs to address with the ambulance service. There is also a need to make sure there are no delays once an ambulance arrives. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a protocol with the London Ambulance Service, which sets out clear arrangements for ambulances arriving at Pentonville to avoid any delay and that ambulance staff have quick access to prisoners in an emergency.

Contacting the man's family

77. The man's family were unhappy about how long it took the prison to inform them that he had died.

78. One of the prison's managers was asked to inform the man's family that he had died. However, because of the circumstances of his death, the manager waited until the investigating detectives arrived. The police wanted to arrest the man's visitor first and wanted to go with him when he informed the family. When they were on their way to see his family, a car in front of them was involved in a serious accident and they had to stop, assist and then make statements.

79. It is important that the prison informs the prisoner's family of their death as soon as possible. We consider it took too long but in the circumstances we accept that the prison was acting in line with guidance from the police and police procedures. The delay was unfortunate but we recognise that this was not within Pentonville's control.

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