

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Williams a prisoner at HMP Pentonville on 26 June 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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.

Mr John Williams was found hanged in his cell at HMP Pentonville on 26 June 2016. He was 54 years old. I offer my condolences to Mr Williams' family and friends.

Mr Williams had a history of attempted suicide, suffered from depression and was diagnosed with dissocial personality disorder. It was a challenge for him to cope in prison and for staff to support him effectively. Staff from different disciplines made concerted efforts to assist Mr Williams and he was often subject to suicide and self-harm monitoring procedures. However, I believe that staff could have managed the risk he presented to himself more effectively through a better use of these procedures.

Staff should have reviewed Mr Williams' behaviour more thoroughly before downgrading him to the basic regime the morning he died, and in particular should have considered more carefully the risk he presented to himself as a result. The situation was almost identical to a previous serious suicide attempt he had made in Pentonville in 2015.

I am troubled that wing staff did not respond promptly to calls from his cell bell. I am also concerned that some prisoners did not feel adequately supported after Mr Williams' death.

The findings and recommendations in this report on the management of risk of suicide and self-harm at Pentonville are ones I have made previously. The prison accepted the recommendations and set out plans to implement them. It is a significant concern that implementation appears not to have been effective.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2017

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Summary

Events

1. Mr John Williams was remanded into custody on 6 July 2015. He was diagnosed with dissociative personality disorder, had tried to commit suicide a month earlier and suffered from depression. On 5 August, staff began Prison Service suicide and self-harm prevention procedures, known as ACCT, because Mr Williams said he intended to hang himself. Staff subsequently closed this ACCT, although we do not know when, as, despite several requests, the prison did not provide the relevant documentation.
2. In October 2015, Mr Williams was found hanging in his cell. Staff resuscitated him and he remained in hospital for two weeks. On return to prison, he was again made subject to ACCT monitoring procedures. In December 2015, Mr Williams was sentenced to 20 months imprisonment and transferred to HMP Onley. On 9 May 2016, he was released on licence.
3. On 28 May, police arrested Mr Williams and, two days later, he was remanded into custody. Staff opened an ACCT as soon as he arrived at Pentonville but this was closed on 10 June. On 16 June, staff opened another ACCT. On 23 June, Mr Williams told staff that he was thinking of hanging himself that evening as he was upset with wing staff. Staff passed this information to the wing Senior Officer (SO) and recommended an increase in Mr Williams' observations. The SO was also sent two emails detailing the background to his previous suicide attempt. The SO did not read these emails or hold an ACCT review.
4. During the evening of 25 June, Mr Williams was feeling agitated. He was intimidating towards an officer and later smashed his observation panel. The next morning, SO A told Mr Williams that he had been downgraded to the basic regime and had lost his job. Mr Williams began damaging his cell, so the SO left. Two prisoners told the investigator that, at around 9.30am, when the SO was standing outside the door, Mr Williams shouted that he was going to kill himself, and to tell his son that he loved him. The SO denied this.
5. Around 10.00am, a prisoner saw through Mr Williams' observation panel that he had hanged himself. He shouted to an officer who radioed an emergency code for staff to attend. Nurses arrived three minutes later and began resuscitation. Paramedics' arrival was delayed by 11 minutes after being directed to a broken prison gate. At 10.30am, the paramedics pronounced Mr Williams dead.

Findings

6. There were procedural failings in the operation of the ACCT process, which meant that Mr Williams did not always receive an appropriate level of support. Case reviews did not take place as scheduled or in accordance with prison service instructions. They were not multidisciplinary, and the caremaps were insufficient. Mr Williams' level of risk was not assessed accurately and his ACCT was closed prematurely on 10 June. Additional case reviews did not take place when there was an increase in Mr Williams' risk, ACCT observations were

carried out at predictable intervals and ACCT documentation did not accompany Mr Williams around Pentonville or when he transferred to Onley.

7. We also consider that Mr Williams' IEP level was not appropriately reviewed. Staff should have done more on 26 June to de-escalate the situation with Mr Williams, particularly in light of his previous suicide attempt taking place under similar circumstances. We are also concerned that Mr Williams had no named personal officer and staff took too long to answer his cell bell.
8. We recognise that the delay in the ambulance getting into the prison had no effect on the outcome for Mr Williams and therefore make no recommendation in this regard. Lastly, we are concerned that not all prisoners were appropriately supported following Mr Williams' death.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
 - First case reviews are completed within 24 hours of an ACCT being opened and further case reviews take place as scheduled.
 - A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.
 - All known risk factors are considered when determining the level of risk of suicide and self-harm.
 - ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for him.
 - ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk.
 - ACCT documents accompany prisoners when they move around the prison or are transferred to another prison.
 - Observations are carried out at unpredictable intervals.
- The Governor should ensure staff adhere to the national guidelines for the IEP scheme, particularly that IEP reviews take place and are documented, that the prisoner has the opportunity to make representations and that a loss of privileges takes into account any identified risk factors.
- The Governor should ensure that when a prisoner is distressed, staff make active attempts to engage with him to de-escalate the situation and address the underlying cause.
- In the absence of and pending the introduction of an effective personal officer scheme, the Governor should ensure that all prisoners have meaningful contact with identifiable wing officers who regularly check their wellbeing and record their contact.
- The Governor should ensure that all cell bells are answered within five minutes.
- The Governor should ensure prisoners are offered appropriate and timely support after a death in custody.

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. Several prisoners responded.
10. The investigator visited HMP Pentonville on 29 June 2016. She obtained copies of relevant extracts from Mr Williams' prison and medical records.
11. The investigator interviewed thirteen members of staff and seven prisoners at HMP Pentonville in June, August and September.
12. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison. The clinical reviewer joined the investigator for the interviews with healthcare staff.
13. We informed HM Coroner for Inner North London of the investigation. We have given the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Williams' sister, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She indicated that she did not.
15. Mr Williams' sister was informed the initial report was available, but did not wish to receive a copy or make any comment.
16. The National Offender Management Service (NOMS) also received a copy of the report. They accepted all the recommendations and their action plan is attached as an annex.

Background Information

HMP Pentonville

17. HMP Pentonville is a local prison that holds over 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.
18. Healthcare services are provided by Care UK in partnership with Enfield and Haringey Mental Health Trust. There is a large purpose-built healthcare centre which has 22 inpatient beds and a daycare facility for patients with mental health problems who are managed on the wings.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Pentonville was conducted in February 2015. Inspectors reported that the prison was running below its agreed staffing level and that staff supervision was often poor. Most prisoners felt unsafe and levels of violence were much higher than in similar prisons. Relatively few prisoners were assessed as being at risk of suicide and self-harm, and processes to support them required improvement.
20. There was no active personal officer scheme and on some of the wings there appeared to be little interaction between staff and prisoners, with staff routinely moving off the wings to work in other areas of the prison throughout the day. Prisoners often expressed their frustrations at their inability to get things done, saying that staff often failed to get back to them or avoided dealing with a request for assistance.
21. Prisoners' views about staff were negative and the poor physical environment was exacerbated by overcrowding. Only around half of prisoners felt that staff treated them respectfully and inspectors witnessed some indifferent responses to prisoners in need of assistance. Inspectors observed long delays in officers answering cell bells and noted that this had also been the case at earlier inspections. Inspectors noted that there was a suitable range of primary healthcare services and some good secondary mental health care and daycare.

Independent Monitoring Board

22. 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 March 2016, the IMB reported that staffing levels remained insufficiently low and that temporary regimes had been introduced as a result. The IMB also found that while adequate medical care was delivered, the support of prisoners at risk of suicide and self-harm needed improving. It recognised that cell bells were misused by prisoners and there was often an unacceptable delay in the subsequent staff response.

Previous deaths at HMP Pentonville

23. Mr Williams was the eighth prisoner to die at Pentonville since June 2014, and the fifth self-inflicted death. In previous investigations, we found that prison staff did not fully consider the risk factors for suicide and self-harm or manage this risk

accordingly. We have previously found that staff took too long to answer cell bells. We also identified these issues in this investigation.

Incentives and Earned Privileges (IEP) Scheme

24. Each prison has an Incentives and Earned Privileges (IEP) 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)

25. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

26. On 6 July 2015, Mr John Williams was remanded into custody for offences of affray, assault and criminal damage and taken to HMP Pentonville. Mr Williams said he had a history of attempted suicide and suffered from post-traumatic stress disorder and depression. A prison doctor prescribed Mr Williams sertraline (an anti-depressant). On 4 August, Dr A, a psychiatrist, assessed Mr Williams and noted he displayed traits associated with dissocial personality disorder which is characterised by impulsive, irresponsible and often criminal behaviour, and a lack of regard for other people's feelings.
27. The doctor referred Mr Williams to the Enhanced Support Service (ESS). ESS consists of three members of staff: Officer A, Nurse A and a forensic psychologist. Their caseload, of twelve prisoners, comprises some of the most disruptive and violent in Pentonville. ESS staff see prisoners in pairs, usually at least once or twice a week.
28. On 5 August, Mr Williams told an officer that he was going to hang himself. Staff began ACCT suicide and self-harm prevention procedures. Despite several requests, the investigator has not had access to Mr Williams' ACCT or main prison record from this period. It is not known when this ACCT was closed. On 12 August, staff from ESS began regular appointments with Mr Williams. As Mr Williams liked to be busy, ESS staff helped him get a job on the wing as a painter. They also worked with him on managing his emotions and interacting with staff and other prisoners. Mr Williams was sometimes volatile and impulsive and could be disrespectful and abusive if angry.
29. On 14 October, an officer told Mr Williams that his mother had died. On 23 October, an officer found he had hanged himself in his cell. Staff resuscitated Mr Williams and he was taken to hospital where he was placed in an induced coma. Mr Williams recovered and, on 4 November, returned to Pentonville where he was monitored using ACCT procedures. He said he had not meant to kill himself but had been angry about not receiving any canteen. He was also annoyed with a supervising officer who told him he might lose his job. Mr Williams' ACCT observations were gradually reduced, a psychiatrist and a mental health nurse continued to monitor him and, at some point, staff closed this ACCT.
30. On 24 November, Mr Williams told the forensic psychiatrist that he had tied ligatures in his cell and that his late mother's birthday fell two days later. The forensic psychiatrist restarted ACCT monitoring. On 10 December, Mr Williams was sentenced to 20 months imprisonment and eight days later transferred to HMP Onley. His ACCT documentation did not accompany him. On 4 January 2016, staff closed Mr Williams' ACCT. A mental health nurse continued to see him fortnightly focusing on his feelings of suicide and self-harm and anger management.
31. On 9 May, Mr Williams was released on licence with a condition to attend probation supervision. He did not respond well to supervision, attending the probation office on a daily basis without appointments, and being aggressive to staff. On 28 May, Mr Williams allegedly made a threatening telephone call to a

- police officer and was arrested. He told a police doctor that he had suicidal thoughts.
32. Mr Williams remained in police custody until 30 May when he appeared in court and was remanded into custody. He had deliberately hit his head on the cell door while at court and the court liaison mental health worker referred Mr Williams to mental health services at Pentonville. He arrived at Pentonville with a suicide and self-harm warning form completed by court staff, and prison staff opened an ACCT at 4.40pm. Mr Williams returned to court on 31 May, arriving back in the prison at 5.50pm. During an ACCT assessment the following day at 10.30am, Mr Williams said he constantly felt suicidal but was unsure whether he actually intended to kill himself. An officer informed ESS, the daycare team and the mental health team that Mr Williams had returned and they all agreed to assess him. A psychiatrist tried to assess Mr Williams twice that day but he was not available.
 33. Supervising Officer (SO) B chaired Mr Williams' first ACCT case review that afternoon at 4.00pm, along with Mr Williams and a reverend. Mr Williams said he wanted to telephone his son and wanted a job in prison. He was assessed as presenting a low risk of harm to himself and the level of observations was changed to once every two hours. Two issues were added to Mr Williams' caremap. The first was to get time out of his cell, which was completed the same day when Mr Williams gained employment as a wing painter. The second issue was telephoning his son. However, following his death, police ascertained that Mr Williams did not have any children.
 34. On 2 June, Nurse B assessed Mr Williams' mental health. The nurse asked Mr Williams how he anticipated coping in prison this time, given his previous serious suicide attempt. Mr Williams said he was not coping. The nurse spoke to an officer regarding a telephone number that Mr Williams wanted. He also spoke to the custodial manager on the wing to inform them of the previous circumstances of Mr Williams' suicide attempt and a doctor later prescribed Mr Williams sertraline. The forensic psychiatrist saw Mr Williams that afternoon. He told her he was coping and would ask to speak to someone from ESS if he started to struggle. On 3 June, the probation service completed a report recalling Mr Williams to custody. Mr Williams was to be subject to a 28 day fixed term recall. On 6 June, Mr Williams appeared in court via videolink. He was remanded in custody until 4 July.
 35. Mr Williams' cellmate, told the investigator that Mr Williams main issues were that he could not make the telephone calls he wanted, was unable to see his son and was not unlocked on time. Other prisoners told the investigator that Mr Williams was generally a cheerful and chatty prisoner although he complained about staff not listening to him or letting him out of his cell on time.
 36. On 7 June, staff discussed Mr Williams in a Mental Health In-Reach Team (MHIRT) meeting. They decided that he would not be accepted onto the MHIRT caseload as he was stable and working on the wing. On 9 June, Mr Williams telephoned the person he said was his son and told him he was in prison. On 10 June, SO B closed Mr Williams' ACCT with himself and Mr Williams present. He

noted that Mr Williams had settled well on G wing and that issues detailed in the caremap had been resolved.

37. On 16 June, Mr Williams had his first daycare session. Daycare provides group activities to help people manage their mood and cope with being in prison. This includes psycho-educational, practical and creative groups. Those referred attend every weekday and also have individual sessions with their keyworker. Mr Williams told an occupational therapist, that he had ongoing thoughts of suicide and self-harm and that his past suicide attempt had been triggered by anger. He said he was not sure whether he would be able to control his emotions in the future. The occupational therapist began ACCT procedures and Mr Williams' observations were set at hourly.
38. On 17 June, during an ACCT assessment Mr Williams said he had no thoughts of suicide or self-harm but would kill himself if the prison "mucks me about." He said he was disappointed that he had not died when he had previously attempted suicide. At 2.50pm, Mr Williams told a substance misuse worker, that he was frustrated he had not been unlocked from his cell to paint the wing and he would make a ligature. The substance misuse worker told a wing officer who let Mr Williams out of his cell for association. SO B held the first ACCT case review with Mr Williams that afternoon. There is no time entered on the review documentation. The SO noted that all Mr Williams' issues were "minor" and Mr Williams said he found it difficult when he was not let out to work. The SO assessed Mr Williams as being at a low risk of harm to himself and reduced his observations to once every two hours. He set the next case review for 27 June. The SO noted the issues on Mr Williams' caremap as: getting time out of his cell, and receiving his medication on time.
39. Supervising Officer (SO) A told the investigator that, around this date, Mr Williams said that he had not been paid correctly for his painting. The SO referred the matter to the accounting department and returned to Mr Williams to tell him he would be paid within a couple of days. The SO said Mr Williams seemed fine with this.
40. On 20 June, Mr Williams told an officer in daycare that he had had a disagreement with a wing officer after his cell bell was not answered, and had thoughts of suicide and self-harm. He said he wanted to die in prison. The officer told a custodial manager on G wing what Mr Williams had said.
41. On 22 June, the forensic psychiatrist met with Mr Williams who requested the support of ESS. The forensic psychiatrist noted that she would book a session for the following week and would check on him before then. The next day, ESS staff saw Mr Williams who was upset at not being unlocked on time. They later returned to speak to Mr Williams who said he was thinking about hanging himself that evening and had tied a ligature. He punched the wall.
42. The forensic psychiatrist told the investigator that she was particularly concerned about Mr Williams due to his previous serious suicide attempt which had taken place in similar circumstances. She informed a wing officer and confirmed that they were aware of the circumstances surrounding Mr Williams' previous attempt. She added information to the triggers section on the front cover of the ACCT that:

“If Mr Williams threatens to harm himself and does not feel listened to, he may follow through on threats to confirm what he said (as in previous near miss).”

43. The forensic psychiatrist also told SO A that Mr Williams had said he might kill himself that evening and that she thought his level of observations should be increased to hourly. The SO told the investigator that she remembered the forensic psychiatrist speaking to her about her concerns but could not remember the specifics of the conversation. She later sent SO A two additional emails with further background to Mr Williams’ previous suicide attempt. The SO did not read these emails until after Mr Williams had died. Officer A, from ESS, went to see Mr Williams on 24 June. He told the investigator that Mr Williams was in a good mood.

25 June

44. The cell bell record for Mr Williams’ cellmate and Mr Williams’ cell for the evening of 25 June shows that it was rung four times. On the first occasion it was responded to promptly. Subsequent responses were not prompt, certainly not meeting the HMIP expectation of cell bells being responded to within five minutes:

Call time	Answer time	Duration
5.35pm	5.36pm	1 minute
6.01pm	6.56pm	55 minutes
7.33pm	7.57pm	24 minutes
8.07pm	9.00pm	53 minutes

It is not known whether Mr Williams’ cellmate or Mr Williams rang their cell bell that evening.

45. Officer B was helping nurses with the evening medication round between 8.00pm and 9.00pm. She asked Mr Williams how he was. He said he was unhappy as he did not have any tobacco and officers did not care about him. The officer took him to SO A’s office. The officer said that less than a minute later, Mr Williams came out of the SO’s office, agitated, swearing and claiming that the officer did not care about him. He told the officer that the SO had said that as it was the end of her shift she could not help him. The SO told the investigator that she did not remember Mr Williams coming to her office but accepted that this happened.
46. Mr Williams continued to shout and Officer B asked him to stand back and calm down. She put her hands in front of her chest to protect herself and he walked into them. SO A heard shouting, came out of the wing office and blew her whistle to alert other staff. The custodial manager who was in charge of the prison that evening immediately attended and stood between Mr Williams and Officer B. Mr Williams then returned to his cell.
47. Mr Williams’ cellmate told the investigator that Mr Williams was upset that evening as he had not been paid correctly and had been unable to order tobacco or food from the canteen to be delivered that day. He said Mr Williams began to damage their cell, breaking a table and the glass in the observation panel. He

said Mr Williams then calmed down; they watched television together and then went to sleep.

48. Officer C wrote in Mr Williams ACCT observations at 9.45pm that he had smashed his observation panel that evening as he did not receive his tobacco from the canteen. He recorded that Mr Williams was currently calm and he had no concerns about him.

26 June

49. On 26 June at 8.30am, during the morning briefing, SO A told staff that Mr Williams' IEP level would be reduced to basic due to his behaviour the night before. She told staff she would speak to Mr Williams that morning and they should not let him out of his cell in the meantime.
50. At 9.20am, Officer D unlocked Mr Williams' cellmate to go to church. Mr Williams, who was standing at the back of the cell, remained calm when told he could not go to church. Shortly after this, SO A unlocked Mr Williams' cell and told him his IEP level had been reduced to basic and he would lose his job. Mr Williams picked up a piece of wood and began to smash his cell saying he wanted to go to church. The SO did not remove his television, as would normally be standard practice, as she did not want to upset him further. The SO backed out of the cell, locked the door and told him that she would speak to him when he was calm. The SO said that, as she walked away, Mr Williams threw paint out of the broken observation panel. The SO asked Officer E to contact the maintenance contractor to have Mr Williams' panel repaired.
51. A prisoner who occupied a cell opposite Mr Williams, on the landing below. He told the investigator that when SO A was standing outside the cell, Mr Williams shouted: "I am going to kill myself. Tell my son I love him." He said SO A then closed the observation panel and spoke to another prisoner two cells away. The prisoner said he could hear Mr Williams smashing his cell. A prisoner who was in the cell two doors along from Mr Williams. He told the investigator that he also heard Mr Williams say these words.
52. When Officer E went to the wing office to telephone the maintenance contractor, she wrote in Mr Williams' ACCT that he was throwing paint out of his observation panel. The officer noted that this happened at 9.45am but told the investigator that, at the time, she was not sure whether it was 9.30am or 9.45am. The time recorded in the ACCT document looks as if it has been changed.
53. Another prisoner opened Mr Williams' observation panel as he noticed the broken glass on the floor. He saw Mr Williams was hanging by a sheet from the window bars. He said his legs were at right angles to his body and he seemed slumped on the floor. He shouted to Officer D at the other end of the landing: "He's hanging, he's hanging." He said the officer did not turn round but held his finger up to acknowledge he had heard him. He said the officer started to come towards him but did not rush and unlocked two cells on the way. The prisoner said he asked the officer to hurry. He said the officer looked through the observation panel on Mr Williams' door and then spoke on his radio for two to three minutes. He said he unlocked the door when a female officer arrived. Two other prisoners also said there was a delay before the officer unlocked the door.

54. Officer D said that, when he heard the prisoner shouting, he went immediately to Mr Williams' cell and called for Officer F to join him. He said there was no delay in reaching the cell and he looked in the observation panel and saw Mr Williams hanging. He immediately radioed a code blue and unlocked the cell. The investigator listened to the radio traffic which indicates that this happened at 10.03am. The control room automatically called an ambulance. Officer D supported Mr Williams' weight and cut him down using an anti-ligature knife. He removed the sheet from Mr Williams' neck and sat him up. The officers tried to elicit a response from Mr Williams by calling his name, moving his limbs and checking for a pulse. The custodial manager, also arrived two minutes after the code blue.
55. Nurses reached the cell at 10.06am. Nurse A told the investigator that when she arrived Mr Williams was kneeling at the back of the cell supported by staff. Two more nurses then arrived. The officers laid Mr Williams on the floor, the nurse confirmed he had no pulse and the other nurses began cardio-pulmonary resuscitation. The nurses administered oxygen using a facemask and attached a defibrillator which advised no shock should be given.
56. The ambulance despatched to the prison went to the Northwall Gate, as directed. Unknown to the communications room, this gate was broken so the ambulance was redirected to the Roman Way Gate on the other side of the prison. London Ambulance Service (LAS) recorded that they reached the prison at 10.15am but did not gain access until 10.26am, a delay of 11 minutes. Paramedics reached Mr Williams at 10.28am. At 10.30am, Mr Williams was pronounced dead. LAS paperwork indicates that Mr Williams' jaw was displaying signs of rigor mortis.

Contact with Mr Williams' family

57. Mr Williams had recorded his son as his next of kin. The prison contacted the police who indicated that Mr Williams did not have a son and that it was not appropriate for the prison to contact this person. The prison manager, telephoned administration support, at 7.00pm and appointed him family liaison officer. She told the investigator that there was a delay as it was a Sunday. There were no Family Liaison Officers in the prison and they were waiting for the police to complete their enquiries regarding the suitability of Mr Williams' listed next of kin. The police then identified that Mr Williams had a sister. The administration support visited Mr Williams' sister's address the next morning. She was not in, so he tried to telephone her and left a voicemail. He also left a note asking her to contact him. Over the next few days, the administration support telephoned Mr Williams' sister several times but did not receive a reply.
58. On 3 July, Mr Williams' sister telephoned administration support. She explained she had been away and they arranged to meet the next morning. The officer told her that Mr Williams had died and offered his condolences. The prison contributed to the costs of Mr Williams' funeral, in line with Prison Service instructions. Several members of prison staff attended.

Support for prisoners and staff

59. After Mr Williams' death, a hot debrief was held for the staff involved in the emergency response to ensure they had the opportunity to discuss any issues

arising, and to offer support. The staff care team also offered support. No minutes of this debrief were available.

60. Staff said that the prison posted notices informing prisoners of Mr Williams' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected. Some prisoners had felt adequately supported while others had not; some said that they did not receive a notice about Mr Williams' death. One prisoner said he had asked to speak to a Listener or the Samaritans but this had not happened.

Post-mortem report

61. At the time of writing the post-mortem report was not available but the coroner indicated that Mr Williams' preliminary cause of death was hanging.

Findings

Management of ACCT procedures

62. We have not had access to ACCT documentation relating to Mr Williams' time in Pentonville in 2015 so this section focuses on the management of ACCT procedures from his return to Pentonville on 30 May 2016. Mr Williams was managed under ACCT from 30 May to 10 June and from 16 June until his death. The investigation identified procedural failings in the operation of the process, meaning that Mr Williams did not always receive an appropriate level of support.
63. Mr Williams' assessment and first case review should have taken place within 24 hours of the ACCT being opened, with the review ideally taking place immediately after the ACCT assessment with the assessor present. While we recognise Mr Williams was at court all day on 31 May, the assessment and review should have taken place immediately on his return to prison and the reason for the delay documented in his ACCT documentation. The first assessment was held the next day, around 42 hours after Mr Williams arrived and the review six hours later, without the assessor present. The next case review scheduled for 9 June did not take place until 10 June.
64. Prison Service Instruction (PSI) 64/2011 states that healthcare staff should attend the first review. This was particularly relevant for Mr Williams, given his mental health issues. In light of this lack of healthcare input we consider that allowing ten days between the first and next case review was too long.
65. PSI 64/2011 also states that caremap actions should be detailed and time-bound, and aimed at reducing the risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress. During both assessment interviews, Mr Williams identified ongoing thoughts of suicide, the circumstances surrounding previous suicide attempts, mental health issues and a tendency to act impulsively or irrationally. These issues were not adequately reflected in the caremap which identified Mr Williams' time out of his cell, receiving medication on time and calling his son as issues. Additionally, at both of the first case reviews (on 1 June and 17 June), SO B assessed Mr Williams' risk to himself as low and reduced his observations. This was despite Mr Williams' ongoing thoughts of suicide, a tendency to act impulsively and, on 17 June, the assertion to a support worker that he had tied a ligature. We do not believe these assessments adequately reflected the risk to himself Mr Williams presented, particularly in light of his earlier serious suicide attempt in Pentonville.
66. At the second case review on 10 June, SO B closed Mr Williams' ACCT monitoring without any input from healthcare. Although the issues identified in the caremap had been addressed, the issues identified at assessment had not. There is no evidence that the SO sought input from the mental health team.
67. In addition to planned case reviews, PSI 64/2011 states that a case review should be held when there are additional concerns. We consider that when, on 23 June, Mr Williams said he was considering hanging himself, there should have been a case review to assess his level of risk. Without a case review after this assertion, his risk remained assessed as low and the level of observations remained at once every two hours. Furthermore, the forensic psychiatrist sent

SO A two emails to ensure she understood the circumstances surrounding Mr Williams' previous suicide attempt. The SO did not read these until after Mr Williams died.

68. Throughout his time at Pentonville, Mr Williams observations were carried out at very regular intervals (for example, on the hour ever other hour), rather than unpredictably, as the PSI instructs. They were also limited to observations, rather than including meaningful conversations. The latter were crucial for Mr Williams who needed to be reassured that staff were listening to him.
69. It is a requirement that ACCT documents always stay with a prisoner. Staff from ESS and daycare said that Mr Williams' ACCT often did not accompany him to appointments. When he transferred to Onley, Pentonville did not send his ACCT documents with him.
70. We are not satisfied that the prison managed ACCT procedures effectively to support Mr Williams. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:

- **First case reviews are completed within 24 hours of an ACCT being opened and further case reviews take place as scheduled.**
- **A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.**
- **All known risk factors are considered when determining the level of risk of suicide and self-harm.**
- **ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for him.**
- **ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk.**
- **ACCT documents accompany prisoners when they move around the prison or are transferred to another prison.**
- **Observations are carried out at unpredictable intervals.**

Staff response to Mr Williams on 26 June

71. The circumstances of the evening of 25 June and morning of 26 June were virtually identical to those around Mr Williams' previous serious suicide attempt in Pentonville, eight months earlier. At that time, he said that he had attempted suicide as he had been angry about not receiving any canteen and a disagreement he had had with a supervising officer who told him he might lose his job as a painter when he refused to be locked in his cell.
72. On 25 June, Mr Williams was upset that he had not received his canteen and had smashed his observation panel and been intimidating towards staff. On the morning of 26 June, SO A told Mr Williams that because of this behaviour, his IEP level had been reduced to basic and he had lost his job. The SO could not remember whether she had made the decision to downgrade Mr Williams.

However, she told the investigator that this was a standard sanction for someone who had displayed intimidating behaviour.

73. PSI 30/2013, *Incentives and Earned Privileges*, states that an immediate IEP review must be undertaken by a member of staff, who is at least a custodial manager, for serious incidents of bad behaviour such as those involving violence. The custodial manager told the investigator that Mr Williams' intimidating behaviour would reach this threshold. There is no record that an IEP review took place and none of the custodial managers recalled completing one. The PSI states that decisions affecting IEP levels must be properly documented and all decisions must be considered alongside ACCT.

74. There is no evidence that an IEP review took place. SO A could not remember whether she made the decision to downgrade Mr Williams to the basic regime. However, she did not have sufficient seniority to make this decision, nor was the timeliness of this decision in line with NOMS policy under which a custodial manager should have held an IEP review with Mr Williams the night before. The SO also told Mr Williams he had lost his job when she downgraded him to basic. This was particularly significant for Mr Williams who found it difficult to cope in prison unless he was out of his cell and occupied. She did not consider the effect of this on Mr Williams' risk of suicide and self-harm. We recommend that:

The Governor should ensure staff adhere to the national guidelines for the IEP scheme, particularly that: IEP reviews take place, are documented, the prisoner has the opportunity to make representations and that a loss of privileges takes into account any identified risk factors.

75. After the SO told Mr Williams he had been downgraded, he started to smash his cell. The SO left the cell as she was understandably concerned for her own safety. While we recognise that if the SO remained in the cell she may have antagonised Mr Williams further, her response was unlikely to have calmed Mr Williams down and there is no evidence that she tried to do so other than by leaving his cell. We believe that the SO should have done more to de-escalate the situation. We recognise that this was made more difficult by the broken observation panel through which Mr Williams threw paint. However, if she felt unable to deal with Mr Williams' behaviour, or she did not think that Mr Williams would respond to her, she ought to have considered asking another member of staff to speak to Mr Williams, such as someone from ESS or daycare, with whom Mr Williams had a positive relationship.

76. The officer who recorded Mr Williams' ACCT observations was unsure whether she had last observed him at 9.30am or 9.45am. The code blue was called at 10.03am. Therefore, Mr Williams remained unobserved in his cell for up to 33 minutes. Given his previous suicide attempt in similar circumstances, staff should have checked on him during this time.

77. Additionally, two prisoners said that Mr Williams told SO A that he was going to kill himself before she walked away from his cell. The SO denies that Mr Williams said this. It is impossible to corroborate either account. The SO had not read her emails from the forensic psychiatrist describing the circumstances surrounding Mr Williams' previous suicide attempt. Had she done so, or reviewed his ACCT when the forensic psychiatrist suggested, it is likely that she

would have realised the risk Mr Williams presented to himself that morning. We recommend that:

The Governor should ensure that when a prisoner is distressed, staff make active attempts to engage with them to de-escalate the situation and address the underlying cause.

Personal officer scheme/meaningful contact

78. The Head of Safer Custody, said that there is no personal officer scheme at Pentonville. He said the large turnover of prisoners, together with the staff to prisoner ratio, made it difficult to implement such a scheme. However, he said that the prison planned to do so. While staff from ESS and daycare clearly had a good knowledge of Mr Williams, he did not have a named point of contact on the wing. It may have reduced his level of distress by improving wing staff's awareness of his concerns and thereby reducing the risk he presented to himself. We note that these findings are consistent with those of HM Inspectorate of Prisons and make the following recommendation:

In the absence of and pending the introduction of an effective personal officer scheme, the Governor should ensure that all prisoners have meaningful contact with identifiable wing officers who regularly check their wellbeing and record their contact.

Response to Mr Williams' cell bell

79. During the evening of 25 June, Mr Williams' cell bell rang four times between 5.35pm and 8.07pm. It is not known whether Mr Williams or his cellmate rang the bell although Mr Williams was clearly agitated that evening. Staff answered these calls within 1 minute, 55 minutes, 24 minutes and 53 minutes respectively.
80. HMIP has an expectation that cell bells should be answered within five minutes. Inspectors have noted at successive inspections that staff at Pentonville do not respond to cell bells as they should. We also made a recommendation following a self-inflicted death in 2014 that cell bells were promptly answered. This was accepted and the prison responded that cell bell response times would be monitored and staff would be reminded to de-escalate situations when a prisoner repeatedly presses their cell bell. We repeat the recommendation that:

The Governor should ensure that all cell bells are answered within five minutes.

Broken observation panel

81. Mr Williams broke his observation panel at some point before 9.45pm in the evening of 25 June. The broken glass remained outside his door after prisoners were unlocked the next morning. The custodial manager, who was the officer in charge of the prison that evening, said she would have expected the broken observation panel to be reported to her but staff did not inform her. We are concerned that broken glass was left on the floor of the wing for over twelve hours. Prisoners were unlocked the next morning and this glass represented a

risk of injury, intentional or accidental, to prisoners and staff. In such situations, the incident should be reported and any hazardous material cleared up.

Emergency response

82. Three prisoners told the investigator that Officer D delayed approaching and opening Mr Williams' cell when he was found hanging. Officer D, Officer F and another prisoner said they went straight in. Without the benefit of CCTV on the wing, it is impossible to corroborate either of these accounts. By the time nurses arrived, three minutes after the code blue, the officers had cut Mr Williams down and were trying to elicit a response from him. Furthermore, the clinical reviewer told the investigator that any delay in going into the cell would not have affected the outcome for Mr Williams.
83. A broken door delayed the ambulance gaining entry to the prison by 11 minutes. The clinical reviewer indicates that, although this was unacceptable, the delay did not contribute to Mr Williams' death as LAS paperwork indicates he was in rigor mortis. We therefore make no recommendation in this regard but we would expect that the Governor ensures staff in the communications room are kept informed, where relevant, of broken facilities.

Prisoner support

84. Some prisoners felt adequately supported after Mr Williams' death while others had not. A number clearly felt aggrieved by Mr Williams' death which they believed could have been prevented. One prisoner said he had asked to speak to a Samaritan and a Listener, but staff did not facilitate this. We make the following recommendation:

The Governor should ensure prisoners are offered appropriate and timely support after a death in custody.

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