Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Pike a prisoner at HMP Pentonville on 16 December 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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.

Mr John Pike died on 16 December 2016 at HMP Pentonville of acute heart failure, resulting from heart disease, incomplete liver cirrhosis, chronic alcoholism and intravenous drug use. He was 57 years old. I offer my condolences to Mr Pike's family and friends.

I agree with clinical reviewer that the clinical care which Mr Pike received while in Pentonville was not equivalent to that which he could have expected to receive in the community. It is particularly troubling that healthcare staff prescribed methadone to Mr Pike without carrying out a proper clinical assessment or adequate review of his medical history. The investigation also found that despite, an officer responding immediately to the cell bell on the day Mr Pike died, there was a delay in calling a medical emergency code.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2017**

Contents

Summary

Events

1. Mr Pike arrived at HMP Wandsworth on 1 November 2016. He tested positive for benzodiazepine and cannabis and was referred to the substance misuse team. Despite this, Mr Pike did not see a prison doctor or receive any prescribed medication while at Wandsworth. He was released on licence on 8 December.

2. Mr Pike's licence was revoked on 9 December and he was arrested on 12 December after being found drunk on a bus. While in custody, a police doctor gave Mr Pike diazepam (benzodiazepine) to counteract early alcohol withdrawal symptoms. Mr Pike was sent to HMP Pentonville later that day.

3. During an initial prison health screen on 12 December, Mr Pike tested positive for opiates and benzodiazepine. The nurse was unaware that he been given diazepam earlier that day, while in police custody. Mr Pike was referred to the prison's stabilisation management unit for drug and alcohol stabilisation.

4. The same day, Mr Pike saw a prison doctor, who prescribed methadone and chlordiazepoxide. A different prison doctor saw Mr Pike the following day. The doctor doubled Mr Pike's methadone dosage after he complained that he was having withdrawal symptoms.

5. Mr Pike did not attend his appointments with the substance misuse doctor on 15 and 16 December. Mr Pike refused to take his chlordiazepoxide at 4pm on 16 December. This was later given at 5.20pm but not recorded properly on Mr Pike's medical record. A nurse took Mr Pike's observations at 5.06pm and recorded that his blood oxygen levels were low at 93%.

6. Mr Pike was not unlocked to receive his evening dose of chlordiazepoxide. An officer on the wing started her roll count at 7.55pm. When she arrived at Mr Pike's cell, his cellmate acknowledged her as she opened the hatch on the cell door. At 8.25pm, Mr Pike's cellmate pressed the cell bell because he thought it odd that Mr Pike had not woken up as usual when the officer had shut the cell hatch and he had been unable to get a response from him. The same officer responded at 8.26pm. She did not open the cell door, explaining that she had to wait for other officers to arrive. She called a code blue emergency at 8.37pm. The Orderly Officer arrived within minutes and opened the cell door. Three nurses and a prison doctor followed a few minutes later.

7. Mr Pike was moved from his bed to the floor. He was not breathing and had no pulse. Cardiopulmonary resuscitation was started at 8.39pm. The ambulance arrived at the prison at 8.42pm. Adrenaline was given at 8.55pm but, when resuscitation attempts proved unsuccessful, it was agreed that resuscitation attempts should stop. At 9.09pm, the prison doctor confirmed Mr Pike's death.

Findings

8. We are concerned that, although Mr Pike was referred to the substance misuse team upon arrival at Wandsworth, he did not see a prison doctor or receive any prescribed medication during his time there. We were informed that this was due

to a computer error that had registered Mr Pike as a prisoner at Brixton rather than Wandsworth.

9. After his arrival at Pentonville, prison doctors prescribed methadone and chlordiazepoxide without a proper assessment of the severity of his opiate withdrawal or a review of his previous clinical records.

10. Mr Pike's oxygen saturation level was recorded as 93% on 16 December (a reading of below 95% is abnormal). There is no evidence to show that the test was repeated to check the accuracy of the result or reported to a senior nurse. The clinical reviewer is of the opinion that the clinical care Mr Pike received while in Pentonville was not equivalent to that which he could have expected to receive in the community.

11. Despite an officer responding immediately to the cell bell on the day Mr Pike died, there was a delay in calling the code blue medical emergency code.

Recommendations

- The Head of Healthcare at Wandsworth should ensure that prisoners referred for drug and alcohol treatment are reviewed and receive the required treatment.

- The Head of Healthcare should review any Care UK and prison specific clinical observation policy to ensure that they include practical advice on repeating clinical observations and what action should be taken when an abnormal reading is given.

- The lead GP should meet formally with the two GPs involved in Mr Pike's care to undertake a structured review of both the care they provided and the records they wrote in this case.

- The Head of Healthcare and Lead GP should review the guidance and prescribing regimes available within the prison to ensure that they reflect best practice and assessment of risk when delivering concurrent drug and alcohol detoxification.

- The Head of Healthcare should review the present system of how staff record that a dose of a drug has been administered when a patient has previously declined.

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and ensure there are no delays in calling for emergency assistance.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Pike's prison and medical records.

14. The investigator interviewed ten members of staff and one prisoner at Pentonville on 20 December 2016 and 8, 21 and 28 February 2017.

15. NHS England commissioned a clinical reviewer to review Mr Pike's clinical care at the prison. The clinical reviewer attended all prison and healthcare staff interviews.

16. 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.

17. A letter was sent to Mr Pike's family on 3 January 2017 to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to this letter.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Pentonville

19. 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.

20. 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 day care facility for patients with mental health problems who are managed on the wings.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Pentonville was conducted in January 2017. Inspectors reported that the prison remained a large, overcrowded local prison with a complex and demanding population.

22. Clinical substance misuse services were provided by Care UK. Drug and alcohol dependent new arrivals received prompt treatment with appropriate monitoring arrangements, but night time observations had not been recorded consistently. Since December 2016, all new arrivals were seen within three days, and those on the drug support units (F and E) could readily access a wide range of group work interventions and mutual aid support, such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous and self-management and recovery training (SMART), as well as peer mentors. The care of patients with both substance and mental health related problems was well coordinated.

Independent Monitoring Board

23. 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.

24. The IMB also found that approximately a third of prisoners are treated as being drug dependent and put on the Integrated Drug Treatment System (IDTS). Most prisoners remain in Pentonville for only a short time which limits the extent of treatment that can be delivered. They recommended that they needed a clear drug strategy which encompasses resettlement to reduce the risk of prisoners, whatever their sentence, walking out of the gate to find the nearest dealer.

Previous deaths at HMP Pentonville

25. Mr Pike was the seventh prisoner to die at Pentonville since January 2016, the third of natural causes.

26. We have made previous recommendations about reminding staff of their responsibilities during medical emergencies in calling emergency codes and asking the Head of Healthcare to ensure that all clinicians adequately review medical records, assess and appropriately examine the patient, taking clinical observations as appropriate in line with national guidelines.

Key Events

Substance misuse treatment in custody, February 2015 to November 2016

27. In February 2015, while at HMP Woodhill, methadone substitution was prescribed for Mr Pike between February 2015 and May 2016. Before his release from prison Mr Pike was referred to community drug services, who could prescribe methadone. There is no clear evidence in the prison medical records to show that he attended any of these services or received any methadone except while he was in prison.

28. On 2 June 2016, in HMP Wandsworth, Mr Pike tested negative for drugs and methadone was not prescribed. Alcohol detoxification was begun. He remained in HMP Wandsworth until 29 June 2016.

29. On 2 July 2016, Mr Pike was sent to HMP Elmley. He left HMP Elmley on 15 July and then returned again on 20 July after a further arrest. Mr Pike remained in Elmley between 20 July and 6 September. On arrival, he tested negative for opiates, cocaine and methadone. Methadone was not prescribed.

30. On 14 September, Mr Pike was remanded to HMP Belmarsh, where a ten-day alcohol withdrawal regime was prescribed. Methadone was again not prescribed. He left HMP Belmarsh on 25 October 2016.

31. On 27 October 2016, while in reception at HMP Thameside, Mr Pike suffered a fit and was treated with rectal diazepam (a benzodiazepine). Further follow up was not possible as Mr Pike was sent to a different prison following his court attendance on 1 November 2016.

Mr Pike's time in custody, 1 November to 15 December 2016

32. On 1 November 2016, Mr Pike was sentenced to 70 days in prison for being drunk and disorderly and was sent to HMP Wandsworth. He was seen and assessed by a nurse, who referred Mr Pike to the substance misuse team when he tested positive for benzodiazepine and cannabis. Despite being referred to the substance misuse team, Mr Pike did not see a prison doctor or receive any prescribed medication while at Wandsworth. Mr Pike was at Wandsworth for 38 days before being released on licence on 8 December. (On 2 February 2017, following this omission, having been brought to Wandsworth's attention, the Practice Operations and Governance Manager & Deputy Head of Offender Healthcare opened an investigation.)

33. Mr Pike failed to comply with the terms of his licence and on 9 December, his licence was revoked. He was arrested in the early hours of 12 December after being found drunk on a bus. While in custody, a police doctor gave Mr Pike diazepam (benzodiazepine) to counteract early alcohol withdrawal symptoms after he told them he was a heavy drinker and would have "whisky as soon as he opened his eyes". Mr Pike was sent to HMP Pentonville later that day.

34. During an initial prison health screen the same day, 12 December, Mr Pike told a nurse that he was homeless, a heavy drinker and a current drug user. Mr Pike

tested positive for opiates and benzodiazepine. The nurse had not seen Mr Pike's prison escort paperwork and was unaware that he had been in police custody and been given diazepam earlier on that day. Mr Pike was referred to the prison's stabilisation management unit for drug and alcohol stabilisation.

35. Mr Pike saw a prison GP the same day. He told the GP that he injected heroin and drank on average seven cans of lager and spirits daily. The GP noted that Mr Pike was 'mildly symptomatic' but did not establish the amount of drugs used or when he had last taken any. The GP prescribed 10mls methadone and 40mg of chlordiazepoxide. He was also unaware of Mr Pike's medication administered while in police custody that day.

36. A prison GP saw Mr Pike at 8.20am the next day, 13 December. Mr Pike had not yet had his morning methadone, having last had it 13 hours previously. Mr Pike complained that he was having withdrawal symptoms as the methadone prescribed was not enough. The GP noted that Mr Pike was "euthymic (normal mood), good eye contact, with normal speech" but experiencing withdrawal symptoms. It is unclear if these withdrawal symptoms were self reported by Mr Pike or witnessed by the GP, as he does not comment further in the medical records. The GP doubled Mr Pike's methadone dosage to 20mls. He did not review Mr Pike's medical record from the previous day.

37. Mr Pike met a Building Futures Support Worker on 14 December. (Building Futures provides support and advice to prisoners with drug and alcohol issues. They provide psychosocial support and assistance with housing in preparation for release from prison.) He made a note in Mr Pike's medical record to say, "seems physically unwell with breathing difficulties and difficulty speaking in a barely audible voice". He did not report his concerns to healthcare staff, presuming that because he had made an entry in Mr Pike's record healthcare staff would review and action if necessary. Mr Pike saw a nurse that evening. His blood pressure was slightly raised at 145/76 with an oxygen level of 98%.

38. At 11.21am on 15 December, Mr Pike attended a secondary health screening and wellman check with a nurse. His blood pressure had now reduced. The nurse noted that Mr Pike was "a little unkempt… [but with] good voice and tone and speech". He also appeared uninterested and angry when being asked questions. The wellman check was not completed that morning, and was finished by a nurse later that afternoon.

39. Mr Pike did not attend either of his appointments with the substance misuse doctor on 15 and 16 December.

40. Mr Pike's medical record shows that methadone should be given once a day at 8am and chlordiazepoxide four times a day at 8am, 11.30am, 4pm and then at 6.30pm. Mr Pike's drug administration chart shows that on 16 December he refused to take his 4pm dose of chlordiazepoxide. Two prison officers were supervising evening medication that night. Their role was to unlock prisoners who needed medication. Mr Pike was not unlocked to receive his evening dose of chlordiazepoxide. There is no entry on Mr Pike's drug administration chart to show what happened.

41. Two officers finished supervising the medication round as another officer started her roll count of the wing at 7.55pm. When Officer A arrived at Mr Pike's cell his cell mate acknowledged her as she opened the hatch on the cell door. She did not get a response from Mr Pike but believes she saw him move in bed.

42. The cell mate thought it odd that Mr Pike had not woken up (as he usually did) when the officer shut the cell hatch. He called Mr Pike's name but was unable to get a response. He pressed the cell bell at 8.25pm. Officer A responded immediately and reset the cell bell outside the cell one minute later at 8.26pm. He was banging on the door and shouting to get out. She was the only officer on the wing at this time. She explained to him that she had to wait for other officers to arrive before she could open the cell door. She called an emergency code blue (indicating that a prisoner is unconscious or is having difficulty breathing) at 8.37pm. (London Ambulance Service records show that a call was received from the prison at 8.38pm.) An Orderly Officer arrived within minutes and opened the cell door. A nurse arrived at 8.39pm, followed by more healthcare staff.

43. After entering the cell, Mr Pike was moved from his bed to the floor. He was not breathing and had no pulse. A nurse started cardio pulmonary resuscitation at 8.39pm. A defibrillator was attached to Mr Pike's chest. A heart rhythm could not be found and no shock was advised. The ambulance arrived at the prison at 8.42pm. Adrenaline was given at 8.55pm, but when resuscitation attempts proved unsuccessful it was agreed by a prison GP, healthcare staff and the ambulance crew that resuscitation attempts should stop. At 9.09pm the GP confirmed Mr Pike's death.

44. The healthcare provider at Pentonville, Care UK, commissioned a Root Cause Analysis Investigation into Mr Pike's death to establish the standard of clinical care provided and identify potential areas for improvement. It found that the assessment of Mr Pike's substance misuse history prior to prescribing him methadone was unsatisfactory.

Contact with Mr Pike's family

45. Mr Pike was homeless. On reception to Pentonville, he did not provide next of kin contact details. When he died, the Head of Safer Prisons, Segregation & Equalities contacted the police to ask for help to find a next of kin. On 21 December the police found details of a sister in Nottingham. Due to the distance from the prison, a family liaison officer from HMP Whatton visited Mr Pike's family to inform them of his death.

46. On 22 December, a family liaison officer from Pentonville telephoned Mr Pike's sister to offer support and answer any questions she may have. He visited Mr Pike's sister in person on 19 January 2017. (Mr Pike's family asked that the prison wait until after Christmas to visit.) The prison contributed towards the cost of the funeral in line with national policy.

Support for prisoners and staff

47. After Mr Pike's death, a prison manager debriefed 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.

48. The prison posted notices informing other prisoners of Mr Pike's 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 by Mr Pike's death.

49. Mr Pike's cellmate spoke to a PPO investigator on 20 December 2016. He was upset by Mr Pike's death and had found it difficult to sleep since. He explained that he had spoken to healthcare staff but been unable to see a doctor. He was unhappy about the support offered to him since the death. He confirmed that he had been offered the support of a Listener (Listeners are prisoners that have been trained by the Samaritans to give support and counselling to other prisoners).

Post-mortem report

50. The post-mortem report shows that Mr Pike died of acute heart failure as a result of ischaemic coronary heart disease, incomplete liver cirrhosis, chronic alcohol and intravenous drug use.

Findings

Clinical care

HMP Wandsworth

51. Although he was referred to the substance misuse team upon arrival at HMP Wandsworth on 1 November 2016, Mr Pike's prison medical record showed no details of any substance misuse treatment during the 38 days he spent there. As a result, the investigator contacted the Practice Operations and Governance Manager & Deputy Head of Offender Healthcare to seek clarification.

52. The Manager was initially unable to explain why Mr Pike did not see a doctor while in Wandsworth or receive any prescribed medication. Mr Pike should have seen the substance misuse team on 13 November, two days after he arrived. In light of this discrepancy, he commissioned an independent investigation.

53. The Manager later explained that "for reasons not known to us, erroneously he [Mr Pike] was registered [as being] at HMP Brixton. This pulled his record from HMP Wandsworth, and in doing so, his appointments for observation were cancelled. This was rectified when the SystmOne upload was next completed, and his record returned to HMP Wandsworth. However, this upload does not reinstate appointments from a 'previous' stay, and so he was no longer showing on the substance misuse caseload".

54. Mr Pike (due to this error) did not see anyone from healthcare until 6 December when he was offered a flu vaccine, which he declined. Mr Pike was released from Wandsworth on 8 December. He did not receive any prescribed medication or undergo any drug detoxification treatment during this period of custody. While this did not have a detrimental effect on Mr Pike's health, it could have had more serious consequences for someone requiring drug or alcohol treatment. We have not had sight of the full investigation report, despite our requests. We make the following recommendation:

    The Head of Healthcare at Wandsworth should ensure that prisoners referred for drug and alcohol treatment are reviewed and receive the required treatment.

55. The post-mortem report shows the cause of death to be acute heart failure. We have reviewed Mr Pike's historical prison medical record as far back as 2010. The medical records do not identify any history of heart disease. Mr Pike complained of chest pain in March 2012, but the records suggest this was non-cardiac related. He did not have a family history of heart disease and the clinical reviewer confirms that a NHS health check in January 2016 showed a cardiovascular 10 year QRISK score was calculated at 20.78%. (A QRISK is a tool used to calculate the risk of having a heart attack or stroke over the next ten years looking at risk factors such as age, blood pressure, smoking status, weight, ethnicity, family history etc.) A QRISK score at this level would have led to lifestyle advice and consideration of cholesterol lowering medication only.

56. A nurse took Mr Pike's observations at 5.06pm on 16 December. His blood oxygen levels were low at 93%. The clinical reviewer confirms that oxygen levels below 95% are abnormal and the test should have been repeated straightaway to establish if the reading was accurate. If it remained at 93% this should have been reported to the nurse in charge. The nurse stated at interview that Mr Pike was not breathless and an oxygen level of 93% 'was okay'. He said that he reported Mr Pike's observations to another nurse. However, the other nurse does not recall any such conversation. It is unclear if staff are fully aware of what they should do when a significant abnormality like this is identified. In light of this we make the following recommendation:

The Head of Healthcare should review any Care UK and prison specific clinical observation policy to ensure that they include practical advice on repeating clinical observations and what action should be taken when an abnormal reading is given.

Drug and Alcohol Stabilisation treatment

57. Mr Pike saw a prison GP on 12 December. The GP noted that Mr Pike was 'mildly symptomatic' but did not establish the amount of drugs he used or when he last took some. Another GP saw Mr Pike at 8.20am the next day, 13 December. He doubled Mr Pike's methadone dosage. Before prescribing he did not review Mr Pike's medical record from the previous day.

58. The clinical reviewer comments in her report that the assessments of both GPs who saw Mr Pike in Pentonville do not record an objective or comprehensive assessment of the severity of Mr Pike's opiate withdrawal. Mr Pike's positive urine sample for opiates and his description of his drug use was noted and this appeared to have prompted the prescription of methadone without a detailed or objective clinical assessment and without consideration of his previous clinical records.

59. The pathologist's report notes the following in relation to methadone:

"The toxicological tests detected therapeutic amounts of chlordiazepoxide (a benzodiazepine) in the blood and its metabolite was present in the urine. In addition, methadone was also detected in the blood, in a concentration (0.25µg/ml) that is considered potentially fatal in people with no methadone tolerance. However, Mr Pike must have built up some tolerance to the effects of methadone".

60. The only tolerance he could have built up to methadone was during the period he received it whilst a prisoner in Pentonville, and not the presumed long term tolerance. The investigation has found no evidence that Mr Pike was prescribed methadone in the six months prior to his arrival at Pentonville.

61. The cause of death given by the Coroner is acute heart failure. The clinical reviewer is unable to say if the level of drug use/methadone prescribed while in Pentonville would have affected Mr Pike's heart as this would be speculative.

62. We found Pentonville's approach to the prescription of methadone to Mr Pike highly concerning. Care UK's Root Cause Analysis Investigation echoes our concerns. The author of this report comments that, "Considering the short period of time that he [Mr Pike] was out in the community, it is unlikely that JP [Mr Pike] would have re-instated a drug habit on the degree he described without experiencing an overdose. Although reinstatement of physical dependence after a period of abstinence is accelerated, those who had previously been dependent on alcohol, it is unlikely he [Mr Pike] would have re-established a dependence requiring full (if any) alcohol detoxification". We make the following recommendation:

The lead GP should meet formally with the two GPs involved in Mr Pike's care to undertake a structured review of both the care they provided and the records they wrote in this case.

63. Mr Pike's medical record shows that methadone should be given once a day at 8am and chlordiazepoxide four times a day at 8am, 11.30am, 4pm and then at 6.30pm. This schedule of drug administration would provide adequate symptom control. However, it appears due to difficulties with the prison regimes this did not always occur. As an example, on 13 December Mr Pike was given 40mg of chlordiazepoxide at 10.29am. This should have been given at 8am. The second dose of chlordiazepoxide was scheduled to be given at 11.30am. This was given at 11.23am, only 54 minutes after his first dose. The clinical reviewer has annexed to her report a detailed table showing the planned schedule for and including the actual time drugs were administered. This table shows that both methadone and chlordiazepoxide were not being administered as per the prison schedule. Mr Pike's cell mate stated during interview that Mr Pike was constantly drowsy and stumbling around as if he was taking too many drugs.

We make the following recommendation:

The Head of Healthcare and Lead GP should review the guidance and prescribing regimes available within the prison to ensure that they reflect best practice and assessment of risk when delivering concurrent drug and alcohol detoxification.

64. On 16 December Mr Pike refused to take his 4pm dose of chlordiazepoxide. The reason for this was not recorded. A nurse spoke to Mr Pike and he later agreed to take it at 5.02pm. Mr Pike's drug administration chart does not reflect this, showing "patient refused". The nurse explained at interview that he was unable to amend the entry on the medical record and decided to make a 'free text entry' instead. After reviewing the online version of Mr Pike's medical record at the prison (and not the paper record provided to us before interview) we were able to view this entry to confirm this. However, this information was not readily available and could cause confusion when administering medication. We make the following recommendation:

The Head of Healthcare should review the present system of how staff record that a dose of a drug has been administered when a patient has previously declined.

65. Mr Pike's next dose of chlordiazepoxide was due at 6.30pm. However because his previous dose had been delayed a nurse decided to delay the dose until later that evening. This decision was not recorded in Mr Pike's medical record. Mr Pike was not unlocked at 8pm by prison staff to receive his medication. An officer told the investigator that Mr Pike's name had been crossed off her list of people to unlock with a note to say he should receive his medication at 10pm. Mr Pike was later found collapsed in his cell.

66. The clinical reviewer is of the opinion that the clinical care Mr Pike received while in Pentonville was not equivalent to that which he could have expected to receive in the community.

The emergency response

67. Mr Pike's cellmate pressed the cell bell at 8.25pm when he discovered Mr Pike unresponsive in his bed. Officer A responded immediately and reset the cell bell outside the cell one minute later at 8.26pm. He was banging on the door and shouting to get out. She confirmed at interview that she was aware (under Pentonville's local instruction) that if there was a perceived risk to life she was allowed to open the cell door alone. However, she explained that during the roll count roughly 20 minutes earlier no concerns had been raised. She was concerned that it could have been a diversionary tactic and as the cellmate was very agitated she risk assessed the situation, deciding that (for personal safety reasons) she would wait for her colleagues to arrive before opening the cell.

68. Officer A told us at interview that on arrival at the cell she immediately called a code blue. However, prison records show that a code blue was called at 8.37pm, 11 minutes after she arrived at the cell. (London Ambulance Service records show that a call was received from the prison at 8.38pm.) Calling a code blue at the earliest opportunity is vital during a situation like this. In light of this, we make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and ensure there are no delays in calling for emergency assistance.

Body-worn cameras

69. At the time of Mr Pike's death body worn cameras were being trialled at Pentonville. Mr Pike's death was recorded as 9.09pm. However, body worn camera footage inaccurately shows resuscitation still being carried out until 9.16pm.

70. In light of our findings, the Safer Prisons Officer has requested guidance on how to manually update the cameras.

Support given to Mr Pike's cellmate

71. The cellmate was unhappy about the support provided to him following Mr Pike's death. During the emergency response, he was temporarily placed into a cell

with two other prisoners. He was later moved to share a cell with another prisoner so he was not alone. He was seen by a mental health nurse on 22 December 2016 and was also discussed at the In-reach referral meeting the following day. It was decided that further follow up was not required. We are satisfied that the support offered to him was appropriate.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141