Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ibrahim Noor, a prisoner at HMP Pentonville, on 7 September 2019

A report by the Prisons and Probation Ombudsman

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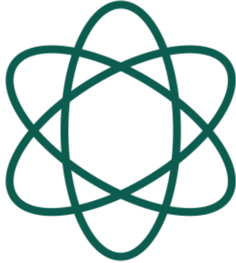
Our vision

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

OGL

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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 Ibrahim Noor died on 7 September 2019 of cocaine toxicity, having been found unresponsive in his cell at HMP Pentonville. Mr Noor was 32 years old. I offer my condolences to Mr Noor's family and friends.

Mr Noor had been at Pentonville for less than two days before he died. Healthcare and prison staff had no concerns about him and he did not seem under the influence of drugs. Mr Noor was subject to a full search on arrival at the prison and I am unable to say when or where Mr Noor obtained cocaine, or indeed when he took it.

The clinical reviewer concluded that Mr Noor received appropriate clinical care, equivalent to that he could have expected in the community. I am satisfied that staff could not have been expected to know that Mr Noor was under the influence of drugs at the time of his death.

I am, however, concerned that staff did not get a response from Mr Noor when they unlocked him on 7 September, which led to a delay in him being found that morning. Another prisoner found him around 45 minutes later and I am also concerned that this prisoner was not appropriately supported immediately after this traumatic event.

I have made other recommendations related to cell bells and the emergency response which would not have affected the outcome for Mr Noor, but might have made a critical difference in other circumstances.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **September 2020**

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Summary

Events

1. On 4 September, police arrested Mr Noor for an alleged offence of assaulting his ex-wife. The next day, 5 September, he was remanded into custody and taken to HMP Pentonville. He arrived around 6.30pm and, after a full search, a nurse referred him to the mental health team and the GP.

2. A GP assessed Mr Noor and prescribed him a sleeping tablet while they were waiting for confirmation of his other medication from his community GP. Staff did not have any concerns about Mr Noor and he consistently denied any substance misuse or thoughts of suicide or self-harm.

3. On 6 September, a healthcare assistant recorded no concerns about Mr Noor at a secondary health screen. It was agreed that he would be assessed by the mental health triage. The community GP confirmed Mr Noor's medication, so the prison GP prescribed risperidone (an antipsychotic) and fluoxetine (an antidepressant) to start the next morning.

4. At 8.30pm, Mr Noor's cell was unlocked so he could collect his sleeping tablet, but he told the pharmacist he did not want it. Mr Noor asked another prisoner to wake him up the next morning as he said he had slept all the previous day. Mr Noor wrote a letter to his mother later that evening, around 10.00pm. Just after midnight he rang his cell bell and an officer responded, but we do not know what Mr Noor wanted or what was said.

5. On 7 September, at around 9.20am, an officer unlocked Mr Noor's cell. Around 30 minutes later, the prisoner went into Mr Noor's cell and tried to wake him up. When he did not respond, he alerted staff, who went to Mr Noor's cell and radioed an emergency code.

6. Prison and healthcare staff responded and attempted to resuscitate Mr Noor. Paramedics arrived around 10.15am but at 10.35am they pronounced Mr Noor dead.

7. The post-mortem report concluded that Mr Noor had died of cocaine toxicity and had heart disease.

Findings

8. There is nothing to suggest that Mr Noor took the cocaine overdose deliberately but this possibility cannot be ruled out. However, we are satisfied that staff could not have been expected to have assessed Mr Noor as a risk to himself.

9. The clinical reviewer concluded that Mr Noor's clinical care was equivalent to that he could have expected to receive in the community.

10. It is not possible to determine when Mr Noor took the cocaine or where he obtained it. This may have happened in the community or in police, court or prison custody. Mr Noor did not seem under the influence of cocaine to staff, he denied any

substance misuse issues and for these reasons his urine was not tested. He was appropriately searched when he arrived at Pentonville.

11. Mr Noor pressed his cell bell four times while he was at Pentonville. We are concerned that twice the bell was answered outside of HM Inspectorate of Prisons' expectation of five minutes. We have recommended that the Governor address this issue in previous investigations, and we repeat our concerns in this report.

12. We are also concerned that when Mr Noor was unlocked in the morning of 7 September, the officer did not get a response from him. This led to a prisoner discovering that Mr Noor was unresponsive around 45 minutes later.

13. This prisoner was not adequately supported immediately after Mr Noor's death.

14. It is also disappointing that the first officer to go into the cell did not radio a code blue.

Recommendations

- The Governor should ensure that all cell bells are answered within five minutes, other than in exceptional circumstances.
- The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor should remind staff that, if they are in any doubt about the nature of a medical emergency, they should act with caution and call a medical emergency code.
- The Governor should ensure that prisoners are offered appropriate support following a death in custody or other traumatic event.

The Investigation Process

2. 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. No one responded.

3. The investigator visited Pentonville on 12 September 2019. She obtained copies of relevant extracts from Mr Noor's prison and medical records. She interviewed the prisoner who had occupied the cell next door to Mr Noor.

4. The investigator and another investigator separately interviewed 17 members of staff between December and March 2020. NHS England commissioned an independent clinical reviewer to review Mr Noor's clinical care at the prison. The second investigator and clinical reviewer jointly interviewed some healthcare staff.

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

6. One of the Ombudsman's family liaison officers contacted Mr Noor's next of kin and Mr Noor's ex-wife to explain the investigation and to ask if they had any matters they wanted the investigation to consider.

7. Mr Noor's next of kin asked:

   - Were prison staff aware that Mr Noor was in possession of and/or had taken cocaine?
   - What steps do prison staff take to find out whether a prisoner has drugs in their possession when they arrive at Pentonville?
   - If prison staff knew that Mr Noor had used cocaine, why did they let him go to sleep?

8. Mr Noor's ex-wife asked (via her legal representative):

   - Was Mr Noor's mental healthcare appropriate?
   - Why did it take staff so long to realise Mr Noor was unresponsive on the morning of 7 September 2019?
   - That the investigation considers the conduct of the family liaison officer appointed after Mr Noor's death.
   - How did Mr Noor have cocaine in his system when he died?
   - Was the vape in Mr Noor's hand when he was found seized and tested forensically?

9. The police confirmed that they did not seize and test the vape which was found in Mr Noor's hand. All the other questions raised are answered in the report.

10. Mr Noor's next of kin and ex-wife received a copy of the issue report. Mr Noor's next of kin did not make any comments. The solicitor representing Mr Noor's ex-

wife wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

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

Background Information

HMP Pentonville

16. HMP Pentonville is a local prison in London that holds around 1,200 prisoners. The prison primarily serves the courts of north and east London. Care UK, in partnership with Enfield and Haringey Mental Health Trust, provides healthcare services at the prison.

HM Inspectorate of Prisons

17. The most recent full inspection of HMP Pentonville was in April 2019. Inspectors reported an increase in violence and the use of force. They found that there was no strategy to reduce the high levels of illicit drugs, despite their ready availability throughout the prison. They also found that the response to recommendations made by the Prisons and Probation Ombudsman following deaths in custody was inadequate and support for those who were a risk to themselves was poor. Living conditions for many prisoners were poor with nearly a third locked in their cells during the working day.

18. Due to their concerns about the prison, inspectors returned to Pentonville in February 2020 to conduct an independent review of progress (IRP). They reported that the prison had made good progress in one out of fifteen of the Inspectorate's recommendations. This was in tackling its significant drug problem. Inspectors noted that there was a coherent supply reduction strategy and the number of prisoners testing positive for drugs had reduced.

19. Inspectors found that the prison had made reasonable progress against a further three recommendations. There had been no meaningful progress against six recommendations and insufficient progress against the remaining five. Inspectors noted that this was highly concerning and the worst progress they had seen in any IRP to date. They wrote to the Secretary of State expressing their concerns and intend to return to Pentonville in November 2020 to conduct a further full inspection.

Independent Monitoring Board

20. 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 2019, the IMB reported that incidents of self-harm had risen over the reporting year.

21. The IMB noted that the poor physical environment at Pentonville was incompatible with maintaining prisoners' humanity and dignity but that many staff were doing their best to treat prisoners humanely. The IMB reported that healthcare at the prison delivered a high-grade professional service and that in mental healthcare, staffing levels were very good, with a rich mix of skills.

Previous deaths at HMP Pentonville

22. Mr Noor was the sixth prisoner to die at Pentonville since September 2017. Four of these previous deaths were self-inflicted and one was from natural causes. None of these previous deaths raise issues relevant to this investigation. However, in previous investigations, we raised concerns about how quickly Pentonville responded to cell bells, which we repeat in this investigation.

23. Since Mr Noor's death there have been three further deaths, two of which were self-inflicted and one was due to natural causes. We are still investigating these deaths.

Key Events

Wednesday, 4 September

24. On 4 September, police arrested Mr Noor for an alleged offence of assaulting his ex-partner. He told a police doctor that he had paranoid psychosis and social anxiety and said he felt uncomfortable when not at home. Mr Noor told the doctor that he was prescribed risperidone (an antipsychotic). Mr Noor told the doctor that he had once headbutted the wall in a police cell out of frustration, rather than to harm himself.

Thursday, 5 September

25. On 5 September, Mr Noor was taken from the police station to court, arriving at 1.20pm. He appeared in court and was remanded into custody until 30 September, with his next appearance scheduled for 11 September via videolink. Mr Noor's person escort record (PER) noted that he had used illicit drugs in 2008 and that he had headbutted a wall in 2012. It also noted he suffered from psychosis, for which he was prescribed medication.

26. At 6.40pm, Mr Noor arrived at Pentonville. An officer searched Mr Noor in reception. He told the investigator that he could not specifically remember Mr Noor. However, he said that the searching procedure for all new prisoners was the same. First, all prisoners go through a metal detector and sit on the BOSS (Body Orifice Security Scanner) chair, which detects if they have any metal hidden on their person. They then have an initial rub-down search. After this, all prisoners are subject to a full search which involves them taking off a piece of clothing, one at a time. No illicit items were found on Mr Noor.

27. An officer spoke to Mr Noor to complete the first night checklist. Mr Noor said he had no previous or current thoughts of suicide or self-harm. He said he suffered from paranoid psychosis and did not want to share a cell for this reason as he had taken his cellmate hostage when last in prison. The officer told the investigator he could not specifically remember Mr Noor. However, he said that if he had been concerned that Mr Noor was under the influence of drugs, he would have referred him to an appropriate service and spoken to his manager.

28. At 8.20pm, a nurse assessed Mr Noor. She told the investigator that Mr Noor seemed "comfortable" and not in any distress. She noted that he was polite and engaged well. She took his blood pressure which was within the normal range. He told the nurse that he suffered from paranoid psychosis and was prescribed risperidone, with which he had been compliant in the community. The nurse noted that he did not exhibit any unusual or disturbing behaviour. He said he had no current or previous thoughts of suicide or self-harm. The nurse referred him to the health and wellbeing team due to his mental health issues. (The team considers all mental health referrals daily from Monday to Friday.) She also referred Mr Noor to a GP.

29. The nurse told the investigator that there was a note dated 2008 on Mr Noor's PER which said he was a user of Class A and B drugs. As the note was more than 10 years old and Mr Noor denied recent drug use and did not appear to be currently

under the influence of any substance, she did not consider that there was any clinical reason to consider this further.

30. At 8.30pm, a prison GP assessed Mr Noor. She told the investigator that Mr Noor looked “very well”. She noted that Mr Noor had pain in his knee following ice skating two days previously and said he had injured his knee in 2018. The GP examined Mr Noor’s knee and had no concerns. He said that he had previously self-harmed by headbutting a wall and had been diagnosed with depression but did not take his antidepressants in line with his prescription, and that he took a lesser dose. Mr Noor told the GP that he had no thoughts of suicide or self-harm. The GP noted that she needed to confirm Mr Noor’s prescription of risperidone and fluoxetine (an antidepressant) in the community. Mr Noor told the GP that he had never misused drugs.

31. The GP prescribed Mr Noor ibuprofen for his knee pain and zopiclone (a sleeping tablet) for three nights. The GP told the investigator that she prescribed zopiclone routinely for new prisoners with mental health issues while they were waiting for confirmation of the medication they were prescribed in the community. The GP told the investigator that she was aware that Mr Noor had been referred to the mental health team who would triage him the next morning and decide what input he needed.

32. Mr Noor was assessed as unsuitable to share a cell due to having taken a cellmate hostage when last in prison. He was allocated a double cell for single occupancy on the third landing of the first night centre.

Friday, 6 September

33. On 6 September, Mr Noor rang his cell bell twice at 9.06am and 9.32am. Staff responded to these bells in two and seven minutes respectively. It has not been possible to determine which officers responded to these bells or what Mr Noor wanted.

34. Prisoners were unlocked at 9.30am for exercise. It has not been possible to confirm whether Mr Noor left his cell at this point.

35. At 9.30am, a pharmacist, confirmed that Mr Noor had last been issued 30 days’ worth of risperidone and 28 days of fluoxetine in the community on 17 July. Mr Noor had not collected any medication since that time (meaning that he had not been taking it in line with his prescription).

36. At 10.45am, a healthcare assistant completed Mr Noor’s secondary healthcare screening. He told the investigator that he could not recall seeing Mr Noor. He weighed Mr Noor and took his blood pressure. Mr Noor was overweight, smoked and his blood pressure was above the ideal. Mr Noor did not disclose any physical or mental health issues. He told the investigator that if he had had any concerns about Mr Noor he would have recorded them.

37. At 11.30am, prisoners were given their lunch in their cells. At 12.00pm, healthcare staff discussed Mr Noor at the Health and Wellbeing meeting. Those present noted that they had limited information, Mr Noor was last in prison ten years ago and their

plan was for him to be assessed by the mental health triage team. Mr Noor was given a dose of ibuprofen.

38. At 12.45pm, staff from the chaplaincy team visited Mr Noor. Mr Noor confirmed he was Muslim and wished to attend Muslim prayers. He said that he had last been in prison twelve years ago. He said that he cared for his next of kin and had recently had issues with his ex-wife. He told the staff from the chaplaincy team that he had had mental health issues in the past.

39. At 1.00pm, the GP noted that Mr Noor's prescription of risperidone and fluoxetine had been confirmed by his community GP. The GP prescribed these medications to be taken once daily at 8.00am, to begin the following day.

40. At 2.40pm, Mr Noor rang his cell bell. A member of staff responded 20 minutes later. It has not been possible to determine who this was or why Mr Noor rang his bell. At 3.00pm, staff unlocked prisoners for association until 4.00pm. After this, they were unlocked in groups to collect their evening meal which they ate in their cells.

41. An officer told the investigator that he saw Mr Noor sometime during association or when he was collecting his evening meal. The officer said that Mr Noor was standing on the wing using his vape, talking to someone. The officer said that he thought Mr Noor asked him something but that he could not recall what. He said that Mr Noor seemed worried and nervous but that this was usual for prisoners in the first night centre. The officer had no concerns about him. At 4.00pm, Mr Noor received his second dose of ibuprofen.

42. Records indicate that the officer did the roll check at 5.30pm. When asked by the investigator, he could not recall doing the roll count but accepted that he had done. The officer finished working on the wing around 6.00pm.

43. An officer worked on the first night centre between 6.00pm and 9.00pm. He told the investigator that he was on patrol, meaning that he had to answer any cell bells and complete observations. At 8.30pm, Mr Noor's medical record shows that he was unlocked for medication.

44. Another prisoner had arrived at Pentonville the same evening as Mr Noor. They were in cells next to each other, but he told the investigator that he had not seen Mr Noor at all that day. He knew Mr Noor because his brother had been at school with Mr Noor, but he had not seen him for many years. The prisoner first saw Mr Noor when they went to the medication hatch that evening. Mr Noor asked him whether they had been let out at all that day. He confirmed that they had been unlocked and Mr Noor said that he had slept all day. Mr Noor told him that other prisoners had stolen items from his cell, including his kettle and vapes.

45. The prisoner said that they spoke about what they had both been doing since they last saw each other. Mr Noor asked him to wake him up the next morning as he said he did not want to sleep all day again. Mr Noor said he wanted to get up and have a shower and make a telephone call. He said that he would wake Mr Noor up in the morning.

46. He said that when Mr Noor was offered a sleeping tablet he declined, telling the pharmacist that he had slept all day and he still felt tired. This is confirmed by Mr Noor's medical record. Mr Noor said to him that he did not know what the matter with him was as he was so tired. He said he did not usually sleep all day. The prisoner and Mr Noor returned to their cells and before they were locked away, Mr Noor reminded him to wake him up the next morning. The prisoner said that Mr Noor seemed "alright", but "a bit lethargic". He did not have any concerns about his health or that he was a risk to himself.

47. Around 8.30pm, an Operational Support Grade (OSG) began her shift on the first night centre. She had also worked the previous night but did not recall Mr Noor or having any significant contact with him. An officer started work around 8.45pm. An officer did the roll check shortly before 9.00pm. He could not remember specifically doing the check that evening but told the investigator that he would have done it before he went home.

48. At 10.00pm, the OSG and an officer did another roll check. The OSG checked the fifth and fourth landings while the officer checked the third and second (there is no first landing). The could not specifically remember checking Mr Noor but accepts that he did. The said that he uses a torch or night light to complete his count if cells are dark.

Saturday, 7 September

49. On 7 September at 12.03 am, Mr Noor rang his cell bell. A member of staff responded two minutes later. Neither the OSG nor the officer could recall who had responded to Mr Noor's cell bell nor what he had wanted. At 6.00am, they both did the morning roll check the same way as the night before with the officer checking Mr Noor. Again, the officer could not specifically remember this check.

50. Around 7.30am, an officer did a roll check. He told the investigator that he checked prisoners by going to each cell, looking through the observation panel and counting how many prisoners were in there. He pressed each cell bell when he did this. Records show that the officer pressed Mr Noor's cell bell at 7.32am. The officer told the investigator that Mr Noor was lying on his bed but he could not remember in what position.

51. At 8.20am, an officer started work. She took over from the officer who gave her a verbal handover and said there were no issues to report from the night shift. At 8.30am, two officers also started working on the wing. Around 9.15am, both officers started unlocking all prisoners on the wing. An officer said that, at the weekend, prisoners received their medication after they were unlocked for association.

52. An officer said that he unlocked the fifth landing and by the time he got down to the second landing where the office was, all the other prisoners had been unlocked. An officer could not remember which landings he unlocked but accepted, during interview, that he could have unlocked the fourth, third and second.

53. The prisoner told the investigator that staff unlocked his cell door around 9.15am and told him it was time for association. He said that the officer did not look into his cell. He looked into Mr Noor's cell on his way to get his medication and told Mr

Noor that he would be back once he had collected it. He told the investigator that Mr Noor was lying face down on the bed. Around 30 minutes later, he returned to Mr Noor's cell to wake him up. He spoke to him and told him to get up. Mr Noor did not respond. He said he would get his kettle from his cell. He returned to his own cell to get his kettle and his vape and then went back into Mr Noor's cell with these items. He put the kettle on to boil and continued to talk to Mr Noor to wake him up. Mr Noor continued to lie face down on the bed and did not respond. He then shook Mr Noor, who still did not respond. He became concerned that Mr Noor had died.

54. The prisoner stood at the door of the cell and gestured to an officer on the floor above that he thought Mr Noor was dead. He did not want to panic other prisoners and therefore did not shout. The officer went straight to Mr Noor's cell. The officer tried to rouse Mr Noor by shaking his arm and pillow and talking to him. The officer then noticed that Mr Noor's skin was quite stiff. The officer checked for a pulse and noted that his neck also felt stiff.

55. The officer called to a second officer on the floor below to come to the cell. She met him at the stairs and explained that she thought Mr Noor was dead as he was stiff. The second officer went into the cell and called out to Mr Noor. He tapped his shoulder. Mr Noor did not respond so the officer radioed a code blue at 10.07am. (This is an emergency code indicating that a prisoner is unconscious or having breathing difficulties.) Control room staff immediately telephoned for an ambulance.

56. A Custodial Manager (CM) responded to the code blue. She estimated it took her around 30 seconds to get to Mr Noor's cell. She saw Mr Noor lying face down on his bed with his hands under his chest. An officer said that she could not wake Mr Noor so the CM called out to Mr Noor but he did not respond. She tried to turn him over but thought he was resisting so stopped. With another member of staff's assistance, they turned Mr Noor onto his side and the CM noticed that his face was slightly blue.

57. At this point, a nurse got to the cell in response to the code blue and checked Mr Noor's pulse but could not detect one. At her request, with other staff who had responded, they moved Mr Noor onto the floor on his back. The prisoner told the nurse that he had been trying to wake Mr Noor for around 30 minutes. She recalled that Mr Noor was not breathing, he was pale and grey and had bluish lips. She told the investigator that Mr Noor was holding a vape which she took from his hand and put on the floor. She tried to tilt Mr Noor's chin back but said that it was "tight" and she could not open it. Another nurse arrived at the cell. He noted that Mr Noor was still quite warm and therefore instructed the CM to start chest compressions which she did. A nurse attached the defibrillator.

58. A nurse attempted to insert an airway but was unable to do so as Mr Noor's jaw was locked. The nurse told the investigator that he thought this was due to rigor mortis. He noted that Mr Noor's arms were curled up to his shoulders and he was unable to straighten them as they were stiff. The nurse administered oxygen and inserted a nasal airway. A nurse noted that Mr Noor's extremities were very cold, there was some discoloration of his arms and his torso was cool, not cold. A nurse took over chest compressions from the CM. Other staff, including a prison GP then assisted with chest compressions.

59. The CM noted that paramedics arrived around 10.15am. They attached their defibrillator, while staff continued to attempt to resuscitate Mr Noor. At 10.35am the paramedics confirmed that Mr Noor had died. Their documentation noted that Mr Noor had signs of rigor mortis.

60. After Mr Noor died, police found a letter to his mother in his cell which he had written around 10.30pm the previous evening. Mr Noor wrote about his plans for the future and gave no indication of being mentally or physically unwell. He said that he hoped prison would give him the space to improve himself. He wrote that he had been locked in his cell all day and had not been unlocked for social activities or exercise.

Contact with Mr Noor's family

61. Mr Noor did not give any next of kin details when he arrived at Pentonville. Police found details of his family members when they searched the cell after Mr Noor's death. An officer was appointed as family liaison officer (FLO). He went to Mr Noor's next of kin's address, along with another member of staff. They broke the news of Mr Noor's death and offered their condolences. At the request of Mr Noor's next of kin, he also broke the news to Mr Noor's ex-wife on the telephone while he was there.

62. The FLO remained in contact with Mr Noor's next of kin. As one of Mr Noor's brothers was a prisoner at HMP Standford Hill, he liaised with the prison about an extension to his compassionate leave to enable him to support the family. The FLO offered a contribution to funeral expenses in line with Prison Service policy and arranged for family members to visit Pentonville to see Mr Noor's cell.

Support for prisoners and staff

63. After Mr Noor's death, the Head of Residence, 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.

64. The prison posted notices informing other prisoners of Mr Noor'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 Noor's death.

65. The prisoner found out that Mr Noor had died when he was interviewed by the police. He said that he was not informed by prison staff or offered any immediate support. The wing observation book made no reference to him finding Mr Noor but implied that Mr Noor had been found by an officer. He said that he has since received support and counselling, but he said that in the immediate aftermath of Mr Noor's death he did not feel adequately supported.

Post-mortem report

66. The pathologist found that there were no injuries or marks that suggested Mr Noor had been subjected to an assault before he died.

67. He noted that he was initially concerned that the discolouration of Mr Noor's lungs was suggestive of carbon monoxide toxicity. However, he was satisfied that this was not the case following toxicological analysis and health and safety inspections at the prison.

68. Exposure to carbon monoxide causes the formation of carboxyhaemoglobin which reduces the blood's capacity to carry oxygen around the body. Exposure to a high level of carbon monoxide can cause respiratory failure, myocardial infarction, loss of consciousness and death.

69. The clinical reviewer said that the level of carboxyhaemoglobin in the blood has to be above 10% to cause symptoms and signs in people who are smokers. The toxicology tests found that Mr Noor had a carboxyhaemoglobin level of less than 5%. The toxicology report states that a post-mortem level of more than 50% is associated with death.

70. The pathologist noted that Mr Noor had significant single vessel coronary atherosclerosis. This is a condition where fatty deposits (atheroma) stick to the walls of the blood vessels in the heart. The pathologist noted that, in the absence of any other significant findings, this would be sufficient to account for a sudden fatal cardiac arrhythmia (a disturbance to the rhythm of the heart as it beats).

71. The pathologist also noted that toxicology tests showed a potentially fatal level of cocaine in Mr Noor's blood. He was not able to determine when, how or how much cocaine Mr Noor had taken before his death. There was also evidence of previous use of cannabis. The toxicological analysis of Mr Noor's hair also showed heavy use of cocaine in the seven months before he died. The pathologist noted that cocaine can accelerate the development of coronary artery atherosclerosis.

72. The pathologist concluded that the cause of death was cocaine toxicity, in an individual with ischaemic heart disease (heart disease caused by narrowed coronary arteries).

Findings

Assessment of risk of suicide and self-harm

11. The post-mortem concluded that Mr Noor died as a result of cocaine toxicity. While there is no evidence to suggest that this overdose was intentional, this possibility cannot be ruled out and we have therefore considered whether staff adequately assessed Mr Noor's potential risk of harm to himself.

12. The only history of self-harm known to prison staff was Mr Noor's assertion that he had headbutted a wall in 2012. Mr Noor told staff that he had no current thoughts of suicide or self-harm, nor did he seem sad or distressed. Mr Noor had some risk factors for suicide and self-harm, as listed in Prison Service Instruction (PSI) 64/2011, *Safer Custody,* such as being charged for a violent offence against his ex-partner. However, we are satisfied that the decision not to start Prison Service suicide and self-harm support measures was appropriate.

Clinical care

13. The clinical reviewer concluded that the healthcare provided to Mr Noor was equivalent to that he could have expected to have received in the community.

Mental Health

14. The clinical reviewer noted that staff appropriately referred Mr Noor to the mental health team and GP on arrival at Pentonville. Mr Noor was discussed in the Health and Wellbeing meeting and staff agreed he should attend a mental health triage appointment. The GP then appropriately prescribed Mr Noor's medication for his mental health issues. The clinical reviewer concluded that there was nothing in either Mr Noor's presentation or medical history which suggested he needed to be seen urgently by the mental health team. No risperidone or fluoxetine were detected in Mr Noor's blood post-mortem, which confirmed that he had not been compliant with this medication in the community.

Physical health

15. The clinical reviewer noted that Mr Noor had several factors for cardiac disease, as well as his cocaine use. These included being overweight, smoking and having, at the last reading, a raised blood pressure. He was offered, but refused, lifestyle advice. The clinical reviewer concluded that Mr Noor's physical healthcare was appropriate for the short time he was at Pentonville.

Substance misuse

16. The post-mortem report indicated that Mr Noor died of cocaine toxicity. The pathologist was unable to determine when he had taken the cocaine, how he had ingested it or how much he had taken. It is therefore possible that Mr Noor took the cocaine in the community or when he was in court, police or prison custody. The post-mortem examination also indicated that he had used cocaine heavily in the seven months before he died.

17. In line with PSI 7/2016, *Searching of the person,* Mr Noor was subject to a full search when he arrived at Pentonville. Nothing was found on his person although it is possible that he may have hidden the cocaine internally.

18. Prison and healthcare staff were clear that Mr Noor did not seem under the influence of drugs. The prisoner said that he had never known Mr Noor to use drugs. Mr Noor also repeatedly told staff that he had no substance misuse issues. Staff did not test Mr Noor's urine since he did not disclose, or appear to have, any substance misuse issues.

19. I am satisfied that staff could not have been expected to know that Mr Noor was under the influence of drugs at the time of his death.

20. The clinical reviewer noted that urine drug screening (UDS) is not a part of any baseline healthcare screening process in UK prisons. She said that UDS helps to identify those for whom drug substitution programmes might be considered, such as replacing heroin with methadone. There are no such programmes for other drugs such as cocaine. The clinical reviewer recommended that the prison should consider the feasibility of offering urinary drug screening to all new prisoners. We draw the Governor and Head of Healthcare's attention to this issue. Depending on when Mr Noor took the cocaine, a test when he first arrived may have alerted prison staff to his cocaine use.

Drug availability at Pentonville

21. We cannot say whether Mr Noor obtained cocaine in prison or brought it into the prison with him. Nor can we say whether he took the cocaine in prison or in the community or in police or court custody.

22. Two code blues were called in Pentonville's first night centre overnight from 6 to 7 September. One of the prisoners who was subject to an emergency response said that he was under the influence of drugs which he said he had been sold by cleaners on the wing. Since Mr Noor's death, prisoners who work as cleaners now live on the first night centre rather than coming from other wings to clean the first night centre. We understand that this was not as a result of Mr Noor's death, but as part of a wider management change to reduce drug supply between wings.

23. In February 2020, the Inspectorate found that Pentonville had made good progress in tackling its significant drug problem over the previous nine months. They noted that there was a coherent supply reduction strategy and the number of prisoners testing positive for drugs had reduced.

24. As Pentonville have made progress in their management of drugs supply in the prison and we have been told of positive changes in the prison to limit distribution, we do not make a recommendation about the management of drugs.

Cell bells

25. Mr Noor pressed his cell bell four times while at Pentonville. These were answered twice in two minutes, once after seven minutes and once after 20 minutes. HMIP has an expectation that cell bells should be answered within five minutes. We have previously made repeated recommendations to the Governor at Pentonville

(although not within the last two years) that cell bells should be promptly answered. We recommend that:

The Governor should ensure that all cell bells are answered within five minutes, other than in exceptional circumstances.

Roll check and unlock procedures

Roll check

26. A roll check is primarily a security check to count prisoners to ensure they are present in their cells, but it is also an opportunity for any immediate concerns about prisoners' safety to be identified and addressed. An officer checked Mr Noor at 10.00pm on 6 September and 6.00am on 7 September. He could not specifically remember doing these checks but signed to say that he had done so. An officer completed a further roll check at 7.32am that morning and pressed Mr Noor's cell bell outside his cell to evidence this. The officer told the investigator that Mr Noor was lying in bed but he could not remember in what position.

27. Mr Noor was found by another prisoner later that morning. They, too, initially thought Mr Noor was sleeping. We do not think it is reasonable to expect staff to wake prisoners up during the night and early morning to check on their wellbeing, and we accept that it would have been difficult for both officers to identify any concerns about Mr Noor. We make no criticism in this regard.

Unlock

28. At morning unlock, officers should take active steps to check on a prisoner's wellbeing. Prison Service Instruction (PSI) 75/2011, *Residential Services*, says:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
>
> "[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

29. An officer unlocked Mr Noor around 9.20am on 7 September. He cannot recall unlocking Mr Noor's cell but accepts that he did. The officer told the investigator that he always looks through the observation panel before opening a door. He said that if the prisoner appeared to be asleep, he would not try to get a response from them. The officer told the investigator that if a prisoner had not come out of their cell by the end of association at 11.00am, he would go and check them. He also said that if a prisoner is prescribed morning medication (as Mr Noor was) and had not come out of their cell to collect it, he would check on them around an hour after he had unlocked them.

30. The officer said that since Mr Noor's death, "Now we all try to make sure we follow the guidelines properly. We've been advised to make sure we get a response all the time." The officer told the investigator that staff had always been expected to get a response but that sometimes this was difficult if they woke prisoners up against their wishes, they became abusive.

31. Mr Noor was found unresponsive by another prisoner around 45 minutes after the officer had unlocked him. We know that Mr Noor was alive at midnight as he rang his cell bell, but we cannot say when he died. Since paramedic documentation notes that rigor mortis had set in when they arrived, it seems unlikely that an effective unlock check would have changed the outcome for Mr Noor, but it might make a difference in other circumstances.

32. Most of the officers we spoke to said that they were not expected to get a response from prisoners when unlocking their cells. We were concerned that one officer said that they would not even look into the cell when unlocking a prisoner. This practice contravenes national instructions and puts both officers and prisoners at risk. We, therefore, make the following recommendation:

    The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

33. A prisoner found Mr Noor and alerted an officer to the situation. The officer went straight into the cell, discovered Mr Noor was stiff in places and was concerned that he may have died. She left the cell and alerted an officer on the landing below that she needed assistance. He immediately went into the cell and radioed a code blue. Without CCTV, it is impossible to determine how long the delay was before staff radioed the code blue, although it does not seem to have been significant and was unlikely to have changed the outcome for Mr Noor, given the paramedics recorded that there were signs of rigor mortis.

34. An officer told the investigator she did not initially radio a code blue as she was more concerned with starting resuscitation. She said that, on reflection, she wished she had radioed a code blue first. PSI 03/2013, *Medical Emergency Response Codes*, says that staff should ensure there is no delay in calling an ambulance. A delay in communicating a code blue would lead to such a delay, as well as a delay in healthcare staff responding. This delay could be critical in other emergencies and we make the following recommendation:

    The Governor should remind staff that they should immediately radio a medical emergency code when they first discover a medical emergency.

35. When a nurse got to the cell, he examined Mr Noor and instructed staff to start resuscitation. The nurse said that he started resuscitation as Mr Noor was warm. He said that once he had made further observations he realised that Mr Noor had been in that condition for a few hours. On reflection, the nurse said that it might have been better to do a more thorough assessment of Mr Noor and subsequently not have started resuscitation.

36. A nurse said that she thought Mr Noor's jaw may have been locked due him having had a seizure. She also said that since Mr Noor's chest was warm she thought there was a chance he could be successfully resuscitated. She also said that her police statement was incorrect which stated that she had thought Mr Noor had rigor mortis in his arms. Furthermore, the paramedics continued to attempt to resuscitate Mr Noor once they arrived.

37. The clinical reviewer concluded that the decision to attempt to resuscitate Mr Noor was appropriate because it was unclear when Mr Noor had last been seen alive and followed the guidelines of the European Resuscitation Council. These say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made based on a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.

38. Although, in retrospect, it became apparent that Mr Noor had not been breathing for a considerable amount of time, the nurses' initial examination did not suggest any signs unequivocally associated with death, including rigor mortis. Therefore, we agree that, in the circumstances, attempting resuscitation was appropriate.

Family liaison

39. The family's lawyer raised concerns about the support they received from the FLO after Mr Noor died. He said that the FLO's conduct had been "deplorable and unprofessional" and that they would be taking action against him.

40. We have reviewed the family liaison log and contacted the FLO. We are satisfied that he acted courteously and in line with the family's best interests. He relayed information in a timely and diligent manner once it was known to him. We recognise Mr Noor's family's frustration at not being able to view Mr Noor's body immediately, or therefore hold the funeral in line with their religious beliefs, but this was entirely outside of the FLO's control. The lawyer also stated that the family had not had the opportunity to view Mr Noor's cell but this visit was facilitated on 8 November.

Support for prisoners

41. A prisoner discovered Mr Noor unresponsive and was understandably upset. He told the investigator that the police told him that Mr Noor had died when they interviewed him. We note that the wing observation book made no reference to his role in finding Mr Noor but recorded that an officer had found him. Other wing officers might not have been aware of the prisoner's actions or therefore considered providing him with additional support. The prisoner acknowledged that, although he had not been well supported immediately after the incident, he had subsequently been offered counselling and support. We make the following recommendation:

The Governor should ensure that prisoners are offered appropriate support following a death in custody or other traumatic event.

Inquest

73. The inquest into Mr Noor's death concluded on 14 July 2023. The cause of his death was confirmed as cocaine toxicity in an individual with ischemic heart disease.

Sue McAllister, CB
Prisons and Probation Ombudsman **September 2020**

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