

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

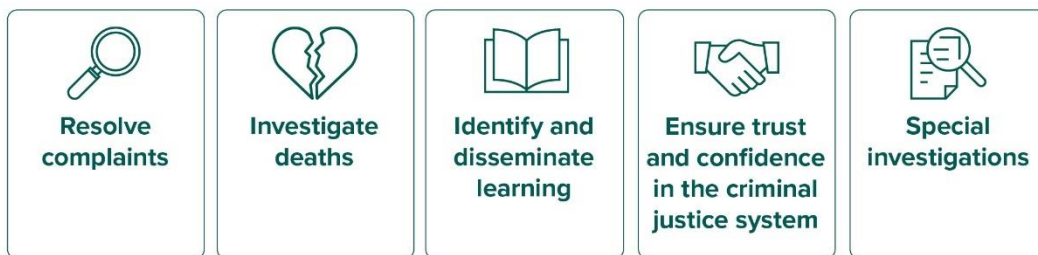
# **Independent investigation into the death of Mr Thomas Walker, a prisoner at HMP Pentonville, on 9 July 2020**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO



## WHAT WE VALUE



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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 Thomas Walker was found hanged in his cell at HMP Pentonville on 9 July 2020. He was 29 years old. I offer my condolences to Mr Walker's family and friends.

Mr Walker had paranoid schizophrenia and antisocial personality disorder. He was also a frequent user of drugs in prison and often reported that he was under threat because of drug debts. His behaviour was often challenging and included assaults on staff and damaging prison property. He was also monitored under suicide and self-harm procedures (known as ACCT) on six occasions.

Staff started the last period of ACCT monitoring on 23 June 2020, after they found Mr Walker with a shoelace tied around his neck. Staff stopped ACCT procedures on 29 June. Mr Walker was not being monitored when he died.

The investigation found that the ACCT procedures were poorly managed. Staff failed to assess Mr Walker's risk properly and missed opportunities to put appropriate support in place. Staff did not start violence reduction measures, despite knowing that Mr Walker feared for his safety as he had drug debts. Staff also managed the ACCT post-closure procedures poorly and failed to identify issues that may have impacted on Mr Walker's level of risk.

I have made repeated recommendations to Pentonville about improving the quality of ACCT assessment and management. In response to a recommendation I made in February 2020, the then Prison Group Director for London wrote to me to assure me that there had been a review of ACCT procedures at Pentonville and new quality assurance procedures had been introduced. I am not confident that these have delivered the improvements required, so I have asked the current Prison Group Director for London to look again at what he can do to improve ACCT management at Pentonville.

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

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# Summary

## Events

1. Mr Thomas Walker was sent to prison in March 2018 and was later sentenced to just over four years for robbery.
2. Mr Walker had paranoid schizophrenia and antisocial personality disorder. His behaviour was often challenging and included assaults on staff and damaging prison property. He was a frequent user of drugs in prison and often reported that he felt under threat from other prisoners because of his drug debts. He was managed under suicide and self-harm procedures (known as ACCT) on five occasions between May 2018 and May 2019.
3. In February 2020, Mr Walker was transferred to a secure mental health unit. He was returned to HMP Pentonville on 21 April.
4. On the evening of 23 June, staff started ACCT monitoring after they found Mr Walker with a shoelace tied around his neck. Mr Walker told staff he was in debt. Staff moved him to another wing and closed the ACCT on 29 June.
5. On 9 July, at around 4.44pm, an officer arrived at Mr Walker's cell to unlock him for medication. The officer found Mr Walker hanging from the window. The officer shouted for assistance and radioed a medical emergency code blue. Prison and healthcare staff quickly responded and attempted to resuscitate Mr Walker. Paramedics attended but at 5.33pm, they declared that Mr Walker had died.

## Findings

6. We found that staff managed the ACCT procedures poorly. Staff did not properly assess Mr Walker's risk, failed to identify appropriate caremap actions, and failed to carry out the post-closure process correctly. We have previously raised concerns about the management of ACCT procedures at Pentonville.
7. Staff were aware that Mr Walker was in debt. Although they moved him to a different wing, no one considered starting violence reduction measures. Staff did not refer Mr Walker to the safety intervention meeting for further discussion about his vulnerabilities and complex needs.
8. Mr Walker had a total of 117 days added to his sentence because of assaults on staff. Initially, staff added only 35 days and gave Mr Walker the wrong release date. When staff gave Mr Walker his correct release date, no consideration was given to the potential impact on his risk of suicide and self-harm.
9. None of the staff who attended Mr Walker's cell in response to the medical emergency used their body-worn video cameras (BWVCs) to record the incident.
10. Although an ambulance was called promptly when Mr Walker was found hanging, and the first paramedic arrived at the prison two minutes later, there was an unnecessary 13 minutes before the first paramedic reached Mr Walker's cell.
11. The clinical reviewers found that Mr Walker received a good standard of mental health care in prison.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular staff should:
  - ensure there is a consistent case manager;
  - consider all relevant information when assessing risk and set the frequency of observations based on the level of risk;
  - set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk;
  - hold a post-closure review within seven days of closure; and
  - ensure all actions and information are properly recorded on the ACCT document.
- The Prison Group Director for London should write to the Ombudsman by 30 June 2021, setting out what he is doing to satisfy himself that effective action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.
- The Governor should ensure that staff:
  - develop a process for identifying unusual canteen spending that may indicate bullying;
  - investigate suspected or alleged bullying in line with the prison's violence reduction policy;
  - support victims of bullying by making CSIP referrals; and
  - refer cases to the Safety Intervention Meeting where appropriate.
- The Governor should ensure that staff activate their BWVCs at the earliest opportunity during any reportable incident.
- The Governor should ensure that there is a local emergency response protocol, agreed with the local ambulance service, so that both prison and ambulance personnel know what the logistical and operational arrangements are when an ambulance is required.
- The Governor should share this report with SO A and SO B and arrange for a senior manager to discuss the Ombudsman's findings with them.

## 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 her. Three prisoners responded.
13. The investigator obtained copies of relevant extracts from Mr Walker's prison and medical records.
14. NHS England commissioned a clinical review to review Mr Walker's clinical care at the prison.
15. The investigator interviewed eight members of staff with the clinical reviewer. In addition, the investigator interviewed 11 members of staff and three prisoners. All the interviews were conducted by telephone or video conference because of the restrictions imposed in response to the COVID-19 pandemic.
16. We informed HM Coroner for London Inner North of the investigation. She gave us a copy of the post-mortem results for Mr Walker. We have sent the Coroner a copy of this report.
17. We contacted Mr Walker's parents and sister to explain the investigation and ask if the family had any issues they wanted the investigation to consider. They asked:
  - How many previous incidents of self-harm or suicide attempts did Mr Walker make?
  - Why was Mr Walker allowed to have clothing and bedding when he was in a single cell and suicidal?
  - Why, given Mr Walker's mental health history and that he had tried to take his life before, did staff accept his word that he was feeling okay and stop ACCT procedures?
  - What medication was Mr Walker prescribed, did he take it and, if not, what was the impact?
  - What cell was Mr Walker in and what access did he have to emergency cell bells, and did he use them?
  - Did Mr Walker have access to the Samaritans using his in-cell telephone?
  - Were staff aware that Mr Walker was in debt and did his excess canteen spends alert staff to the possibility he was buying drugs?
  - Why did Mr Walker have time added to his sentence?
18. Mr Walker's family received a copy of the initial report. They did not identify any factual inaccuracies.
19. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

## Background Information

### HMP Pentonville

20. 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

21. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Pentonville in April 2019. Inspectors said that ACCT support processes remained weak and were generally poorly managed. They reported that many ACCT caremaps were inadequate, that there was no continuity of case ownership and that there was limited multidisciplinary involvement in case reviews.
22. Inspectors reported that about a third of prisoners said they felt unsafe and that levels of violence were high. Inspectors found that investigations were currently not being completed and the Prison Service's new case management approach to managing perpetrators of violence and supporting victims (CSIP) had not yet been introduced. Inspectors reported that the prison suffered from under-investment, was in a generally poor physical state and much of the accommodation was in poor condition.
23. Inspectors noted that of the PPO recommendations made following deaths in custody, nearly all about healthcare had been met, but most of the other PPO recommendations had not been achieved.
24. HMIP carried out an Independent Review of Progress (IRP) in January 2020. Inspectors found that no meaningful progress had been made on improving ACCT management, reducing violence or on implementing PPO recommendations.

### Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 March 2020, the IMB reported that incidents of self-harm had risen by 14% over the reporting year. The number of prisoners monitored under ACCT procedures had also risen.
26. The Board noted that although the CSIP scheme had been mandatory across the prison estate since February 2019, it had not been implemented at Pentonville until January 2020, at which point two prisoners were admitted to the scheme. The Governor told the Board that based on Pentonville's violence diagnostics, a far higher proportion than the 1-2% estimated by HMPPS should be engaging with CSIPs. As no safer custody meetings had been held between November and March, the Board had not seen the CSIP figures and could not comment on how the initiative was progressing.

## **Previous deaths at HMP Pentonville**

27. Mr Walker's death was the eighth at Pentonville since July 2018. Of the previous deaths, five were self-inflicted, one was drug-related, and one was from natural causes. Since Mr Walker's death, there has been one further self-inflicted death.
28. In our previous investigations into self-inflicted deaths at Pentonville, we have identified concerns about risk assessment and the quality of ACCT procedures.

## **Assessment, Care in Custody and Teamwork (ACCT)**

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*.

## Key Events

30. On 23 March 2018, Mr Thomas Walker was remanded in custody, charged with robbery and theft offences, and sent to HMP Thameside. He was subsequently sentenced to four years, three months and 25 days in prison and was due to be released on 17 August 2020. This was not his first time in prison.
31. Mr Walker had paranoid schizophrenia (a chronic mental health disorder where a person loses touch with reality) and antisocial personality disorder (a mental health condition where a person consistently shows no regard for right and wrong and ignores the rights and feelings of others). He was prescribed regular medication to help him manage his symptoms (a depot injection which slowly releases antipsychotic medication into the body over several weeks).
32. Mr Walker had a long history of alcohol, cocaine, heroin and cannabis use and when in prison he often used psychoactive substances (PS - also known as 'Spice') and found himself in debt as a result. Prison staff moved him between wings on numerous occasions, and the substance misuse and mental health teams regularly met with him to discuss his risky behaviour, including his refusal to take his prescribed medication.
33. Between May 2018 and May 2019, there were five reported incidents of Mr Walker making ligatures or threatening to self-harm. He was supported under Prison Service suicide and self-harm prevention measures (known as ACCT) on each occasion.
34. Mr Walker spent time at HMP Wormwood Scrubs, HMP Pentonville, Thameside and HMP Onley, before he returned to Pentonville on 11 April 2019. His behaviour was exceptionally challenging towards staff and prisoners and there are numerous reports of him spitting, throwing urine and faeces, being sexually inappropriate, intimidating women and making racist comments, and he frequently smashed and flooded his cell.
35. On 28 July, Mr Walker was moved to the care and separation unit (CSU) because of his challenging behaviour. On 7 August, he started a dirty protest (where a prisoner deliberately defecates or urinates in a cell without using the facilities provided). Mr Walker assaulted staff on three occasions and in September, 117 additional days were awarded as punishment. However, in error, only 35 days were added, and his release date was incorrectly recalculated as 21 September 2020. Mr Walker continued his dirty protest until he transferred to HMP High Down on 1 October 2019.
36. Mr Walker was located in the segregation unit for much of his time at High Down, although he also spent some time in the inpatient unit. His behaviour continued to be challenging.
37. On 6 December, staff referred Mr Walker for an assessment for transfer to a mental health unit. On 19 December, the John Howard Centre assessed Mr Walker. On 30 December, they told the prison that Mr Walker's risk to others did not justify admission to a medium secure unit, but they agreed that Mr Walker needed hospital treatment. On 31 December, the prison referred Mr Walker to the low security psychiatric intensive care unit (PICU), Titian Ward, at Goodmayes Hospital.

38. On 9 January 2020, Titian Ward told the prison that an assessment would take place on 4 February. The psychiatrist at High Down contacted Titian Ward the next day to raise concerns about the length of time between referral and assessment and that Mr Walker was living in squalid conditions because of his continued dirty protest and was psychotic.
39. On 4 February, Titian Ward completed a psychiatric assessment and the next day confirmed that transfer was appropriate and that a bed was available two days later.
40. On 6 February, Mr Walker transferred to Goodmayes Hospital under Section 47 of the Mental Health Act.

### **Return to Pentonville from Goodmayes Hospital**

41. On 21 April, Mr Walker was discharged from Goodmayes Hospital under Section 50 of the Mental Health Act and returned to Pentonville. He was discharged on the basis that his behaviour was considerably more settled, his remaining behavioural issues were as a result of his personality disorder, not mental illness, and his antipsychotic medication could be administered in prison.
42. A nurse completed Mr Walker's reception health screen and referred him to the prison GP and the mental health in-reach team (MHIRT). A prison GP saw Mr Walker later that day and prescribed all the medication that had been started at Goodmayes Hospital. Mr Walker told the GP that he did not want his medication and that he would not be leaving his cell to collect it as he wanted to isolate himself from COVID-19, but would take his medication if it was brought to his cell.
43. On 28 April, staff discussed Mr Walker at the MHIRT meeting. They appointed, a community psychiatric nurse (CPN), as Mr Walker's allocated nurse and arranged a routine appointment with the psychiatrist. The CPN completed a comprehensive risk assessment and Mr Walker said he was willing to engage with staff, appeared settled in mood and mental state, and was complying with his depot medication; he said he did not have any active thoughts of self-harm. The CPN told wing staff that if Mr Walker's mental health state started to deteriorate, consideration would be given to moving him to the prison's inpatient unit.
44. On 7 May, Mr Walker's Cell Sharing Risk Assessment (CSRA) was reviewed and increased to high. There is no record in his prison or medical record to indicate what prompted this review. The entry on Mr Walker's prison record notes that he had mental health issues, had been on a dirty protest and staff reported some strange behaviour. Therefore, due to his assessed level of risk to others, Mr Walker was in a single cell.
45. On 27 May, an officer saw Mr Walker acting suspiciously around other prisoners' cells and suspected he was under the influence of drugs. Two days later, an officer saw Mr Walker receive something from another prisoner: he had a piece of paper in his hand which later tested positive for PS.
46. On 31 May, an officer submitted an intelligence report which stated that Mr Walker's canteen sheet (list of purchases from the prison shop) had been handed to the night officer by other prisoners and there was a suspicion that he and another prisoner may have been being bullied. Further security information is recorded about a money transfer request that Mr Walker had made for £150.

47. On 4 June, Mr Walker broke his sink and flooded his cell. There are no other details recorded about this incident.
48. On 14 June at 7.20pm, Mr Walker asked to speak to a Listener (prisoners trained by the Samaritans to offer support to prisoners who are struggling to cope) which was granted.
49. On 15 June, an administrator in Pentonville's Offender Management Unit (OMU), recalculated Mr Walker's release date and the remaining 82 additional days, which had not been included in September 2019, were added. We do not know how or when Mr Walker was informed of his revised release date of 12 December 2020.
50. On 22 June, Mr Walker refused to have his antipsychotic medication. The next day the CPN went to Mr Walker's cell to encourage him to take his medication, but Mr Walker said he would continue to refuse, unless he was moved from G Wing. The CPN saw that Mr Walker had numerous cut wires from a radio and kettle, which he was using as a lighter (presumably to smoke drugs). Mr Walker said he was in debt and he had had his canteen purchases taken from him. The CPN recorded that he would discuss the issues with the wing manager and the safer custody team and advise healthcare colleagues.

### **ACCT – 23-29 June 2020**

51. At 9.30pm, during a routine count of prisoners, staff found Mr Walker with a shoelace tied around his neck. An officer started suicide and self-harm monitoring (known as ACCT). Mr Walker said he wanted to die because he was innocent, that he had tried earlier but the ligature had snapped, and that he would try again. A Custodial Manager (CM) completed the immediate action plan. He set observations at one an hour. He gave Mr Walker information about how to access the Samaritans and Listeners. Staff recorded that Mr Walker was asleep at 9.45pm and slept throughout the night.
52. On 24 June, at 2.45pm, a Supervising Officer (SO) completed the ACCT assessment. Mr Walker told her he was unhappy with his sentence, and that he had previously tied ligatures and had committed offences in order to get help. The SO noted that Mr Walker had had his antipsychotic injection with a lot of encouragement from the mental health team, but that he did not think he had a mental health condition. Mr Walker said if he moved wings all his problems would be solved as he was a heavy user of PS, had accrued debts on G Wing and was being bullied. Mr Walker told the SO that he had no family support.
53. After the ACCT assessment, SO A chaired Mr Walker's first ACCT review with another SO, the CPN and Mr Walker. SO A noted that Mr Walker said he was being bullied, that drugs were an issue for him and that other prisoners on G Wing were trading his canteen purchases for PS. SO A noted that Mr Walker would be referred to the substance misuse team for support and that he was already engaged with the mental health team, and he told Mr Walker that a move to D Wing had been authorised. There is no evidence the referral to the substance misuse team was made. The review considered that Mr Walker's risk of suicide or self-harm was low, and reduced observations to one every three hours and two conversations a day. SO A added one action to the caremap, for Mr Walker to move to D Wing.

54. Although not recorded on the ACCT review, the CPN noted in Mr Walker's medical record, '[Mr Walker] was also told about the added days to his sentence which he did not seem bothered by... a SO checked his [Mr Walker's] system and realised a lot of money has come out of his accounts, last week 167 pounds was taken out and also had 99 pounds worth of canteen which he says they take off him. Mr Walker told us that people are selling spice [PS] to him and mentioned some cells to the officers.'
55. At 5.27pm, the SO emailed the business hub manager, and copied in the SOs on C/D Wing and confirmed an earlier conversation they had had. She told the business hub manager that Mr Walker was being bullied and that he was spending large sums of money in his canteen, which was being taken from him by other prisoners. She requested, 'Any finance queries from him [Mr Walker] must be emailed directly to you from staff and no apps should be accepted from him.' The business hub manager acknowledged the request the next morning.
56. The wing observation book shows two entries on 25 June about Mr Walker. Prisoners had reported that he was going from cell to cell asking for PS. A later entry noted that at 4.10pm, Mr Walker had pressed his emergency cell bell and appeared to be under the influence: his eyes were glazed and his speech slurred.
57. On 28 June, during an ACCT check at 3.04am, Mr Walker told the night officer he was in serious debt on G Wing. The officer recorded on the ACCT ongoing record that he would leave a note for the day staff about a wing move. The officer made an entry in the wing observation book at 3.08am that Mr Walker was self-isolating due to debt and asked for a move to be considered 'ASAP'. He also submitted an intelligence report. There is no evidence this was followed up.
58. On 29 June at 9.05am, an officer recorded on the ACCT ongoing record that Mr Walker had refused to collect his medication and went back to sleep. At 10.00am, a SO chaired the ACCT review with a nurse and Mr Walker. The SO had taken Mr Walker to the healthcare centre for his review and for him to collect his medication. Although it is recorded on the ACCT review that the CPN attended this review, he was undertaking other duties. The CPN did not attend and was not informed of the outcome of the review.
59. The SO recorded that Mr Walker had told him he was under threat on D Wing as he owed £50, but that he was 'fine', and his only concern had been to get a move from G Wing. Mr Walker said he had no thoughts of suicide or self-harm. The SO told Mr Walker to speak to him if he had any problems getting his medication and that he would arrange for him to be taken to healthcare. The review agreed that the ACCT should be closed. A post-closure review was scheduled for 6 July.

### **30 June – 8 July**

60. On 30 June, Mr Walker refused his medication because he said he did not need it. Later, Mr Walker was given a new television but warned it was his last opportunity because he had damaged others. This was the last behavioural entry in Mr Walker's prison record before he died.
61. According to an entry in the wing observation book at 7.50pm on 1 July, Mr Walker had asked for a specific Listener, but when told he could only speak to the duty Listener, he refused to see them.

62. On 6 July, a nurse saw Mr Walker to administer his antipsychotic medication. He refused and became agitated when she tried to encourage him to accept and so she ended the appointment. The nurse noted that another attempt to administer the medication would be made the next day.
63. On 7 July, the nurse went to see Mr Walker but, despite encouragement, he refused his antipsychotic medication. The nurse told Mr Walker that he had an appointment with the consultant psychiatrist on 8 July, and that he could discuss his medication issues with him.
64. Although the ACCT had been closed, there is an entry on the ongoing record at 2.30pm by the mental health team which noted Mr Walker had not had his antipsychotic medication and denied having any suicidal thoughts.
65. SO B completed the ACCT post-closure review, which had not been completed as scheduled the previous day; the time of the review is not recorded. SO B recorded that Mr Walker said he had no support from friends or family but that he felt well supported while on ACCT measures and his issues had been resolved. SO B incorrectly noted that Mr Walker was due for release in September.
66. On 8 July, a consultant psychiatrist reviewed Mr Walker and they discussed the reasons why he refused to take his medication. The consultant psychiatrist recorded that Mr Walker was clear that he did not want to be on antipsychotic medication and when he tried to explain how the injection worked, Mr Walker accused him of pushing the medication on him. The consultant psychiatrist told Mr Walker that he could not be forced to take the medication, but explained the risks associated with not taking it. The consultant psychiatrist recorded that he attempted to offer Mr Walker alternative oral medication, but Mr Walker ended the meeting. The consultant psychiatrist discussed Mr Walker with the CPN. They agreed Mr Walker would be monitored weekly, that antipsychotic injections would continue to be offered and that a transfer to the prison's inpatient unit would be considered if Mr Walker's mental state deteriorated.
67. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. All prisoners can telephone the Samaritans directly, without having to ask staff for permission and do not need any phone credit. Following his return from Goodmayes Hospital Mr Walker made a total of 110 calls, all to his father, totalling just over six hours. During some of these calls Mr Walker asked his father for money, but he replied that he would not give him money as Mr Walker would only spend it on drugs. Mr Walker sounded under the influence of drugs during at least one of these calls.
68. On 8 July, Mr Walker made five calls to his father. During a call made at 6.43pm, which lasted for over 12 minutes, Mr Walker said to his father that he was depressed and that 'suicide is an option'. Mr Walker's father checked that he had the telephone number for the Samaritans.
69. The next call was made at 8.20pm and lasted around four minutes. Mr Walker said he could not get in contact with the Samaritans or Listeners and that he had used his buzzer (emergency cell bell) to ask staff for the number. Mr Walker said he had been pacing up and down in his cell and his father said that was because he had not had his medication. Mr Walker told his father that all he cared about was him, and that he had no one else in his life. His father responded that he could not trust

Mr Walker 'with everything that had gone on'. Mr Walker told his father he was suicidal, and his father encouraged him to speak to someone. Mr Walker replied there was no one he wanted to talk to, and his father told him again to call the Samaritans. Mr Walker said there was nothing he wanted to do with his life and his father said, 'That's what happens when you don't have your injection.'

70. The last call Mr Walker made was at 8.35pm, which lasted nearly nine minutes. Mr Walker asked his father to forgive him. His father replied that he did forgive him but was not going to forget it (although they did not discuss anything specific) and Mr Walker asked if they could put it in the past and not talk about it.
71. Cell bell records confirm that Mr Walker pressed his emergency cell bell on four occasions between 6.46pm and 8.11pm. On three occasions it was answered by a member of staff in less than five minutes and on the other occasion it was answered after six minutes. There is no record of why Mr Walker had used his emergency cell bell in either his prison record or wing observation book.

## 9 July

72. On 9 July, Mr Walker used his emergency cell bell on four occasions: 10.44am, answered in just under five minutes; 11.04am, answered after 29 minutes; 11.54am, answered after 14 minutes; and at 12.32pm, when there is no record of when or if it was answered because the cell bell system was routinely de-activated to generate reports for analysis. There is no information recorded as to why Mr Walker wanted the attention of staff.
73. CCTV shows Mr Walker collected his lunch, which was served between 11.30-11.45am, and returned to his cell. An officer went to Mr Walker's cell at 3.14pm, unlocked his door and placed his dinner pack on the table. The officer said Mr Walker was standing looking out of the window but turned around and walked towards the table as she closed the door. She did not recall any meaningful interaction with him but said she did not notice anything of concern.
74. CCTV shows at 3.23pm a prisoner trained as an Insider (who assists other prisoners with prison issues and making applications) briefly stopped outside Mr Walker's cell before continuing along the landing. The prisoner did not recall why he had stopped outside Mr Walker's cell, but said he had no contact with him.
75. CCTV shows the officer started to unlock prisoners for their medication. She unlocked another prisoner, before moving to Mr Walker's cell at around 4.44pm. She opened the door and it is evident the officer is shocked. She saw Mr Walker suspended by a ligature attached to the window of the cell. The officer went straight into the cell and called a medical emergency code blue (used when a prisoner is unconscious or having breathing difficulties) which alerts healthcare staff and tells the control room to call an ambulance.
76. The prisoner was behind the officer and heard her shout for help. He immediately went into Mr Walker's cell and supported his body while the officer removed the ligature. The prisoner and the officer placed Mr Walker on the floor in the recovery position and checked his breathing and for a pulse. The SO and another officer responded to the code blue, shortly followed by a second SO. The prisoner left the cell. The officer and the SO both said Mr Walker was cold and they thought he was dead.

77. A nurse responded to the code blue with a second nurse. The first nurse said that Mr Walker was cold, his lips were blue and there was significant swelling around his neck. They started cardiopulmonary resuscitation (CPR) and attached an automatic defibrillator. Four other nurses were also present as they had responded to the code blue.
78. London Ambulance Service records show they received a request for an emergency ambulance at 4.45pm. The first paramedic arrived at Pentonville at 4.47pm but did not reach Mr Walker's cell until 5.00pm and noted 'delay getting to patient'. A CM, the operational manager, said in his statement that the delay was due to a paramedic refusing to hand his mobile telephone to gate staff before entering prison and staff sought advice before the ambulance could continue. The Deputy Governor gave permission for the paramedic to enter, if it was a work mobile, but when the CM contacted the gate the paramedic had already handed the phone to prison staff. Paramedics recorded Mr Walker had a deep ligature mark around his neck, that his blood had started to pool, and he had rigor mortis in his jaw, all signs he was dead. At 5.33pm, paramedics recorded Mr Walker was dead.

### **Information after Mr Walker's death**

79. The prisoner said that the day before Mr Walker died, he had encouraged him to clean his cell. He said the cell was dirty and messy and that Mr Walker's kettle had been burnt out (and he thought that he may have used it for something other than boiling water). He said Mr Walker's mattress was on the floor and he helped him put it back on the bedframe. He said Mr Walker had very few possessions in his cell, other than packets of noodles and empty sugar sachets. The prisoner said he felt disappointed, as later that day Mr Walker offered him PS as a thank you for helping him, although he did not physically see any drugs.
80. Another prisoner, said he had witnessed other prisoners taking advantage of Mr Walker, but did not see him being bullied directly. He said Mr Walker was vulnerable and prisoners took advantage of him. He speculated that Mr Walker was trading his canteen for drugs.

### **Contact with Mr Walker's family**

81. On 9 July the prison appointed a prison chaplain, as the family liaison officer (FLO) and an officer as her deputy. While under normal circumstances next of kin should, wherever possible, be informed of a death in person by a FLO, Government advice at the time prohibited all but essential travel and required social distancing to prevent the spread of the COVID-19 virus. The Deputy Governor took the decision to inform Mr Walker's sister of his death by telephone. The prison provided ongoing support and contributed towards the costs of Mr Walker's funeral, which was held on 3 August, in line with national policy.

### **Support for prisoners and staff**

82. After Mr Walker's death, a prison manager and the Deputy Governor debriefed all 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.

83. The prison posted notices informing other prisoners of Mr Walker'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 the death. The prisoner, who had assisted staff when Mr Walker was discovered, said he felt very well supported.

### **Post-mortem report**

84. The post-mortem report concluded that Mr Walker died from hanging. Toxicology results showed that Mr Walker had not taken any drugs, other than those prescribed, in the hours before his death.

## Findings

### Management of risk of suicide and self-harm

85. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that staff should follow when they identify prisoners at risk of suicide and self-harm.
86. Staff appropriately started ACCT procedures on the evening of 23 June after they found Mr Walker with a shoelace tied around his neck. He told an officer that he had tried to hang himself earlier but the ligature had snapped. He also said that he intended to try again.
87. Staff stopped ACCT monitoring on 29 June, nine days before Mr Walker was found hanging. We found deficiencies in the way the ACCT procedures were managed: staff's assessment of Mr Walker's risk was inadequate, they missed opportunities to put appropriate support in place and they handled the post-closure process poorly.

### Assessing risk and setting observations

88. SO A chaired the first ACCT case review on the afternoon of 24 June, less than 18 hours after staff had found Mr Walker with a shoelace tied around his neck and he had told them he had tried to hang himself earlier and would try again. Despite this, staff assessed Mr Walker's risk as 'low' and reduced observations from one an hour to one every three hours. As Mr Walker had very recently attempted suicide, we consider that his risk was at least 'raised', if not 'high' (on a scale of low, raised and high), and that staff should have set a higher frequency of observations. (According to the ACCT document, risk is 'low' where suicidal thoughts are fleeting and soon dismissed and there is no self-harming behaviour; risk is 'raised' where suicidal ideas are frequent but generally fleeting and there are previous, especially recent, suicide attempts; risk is 'high' where frequent suicide ideas are not easily dismissed and there is an escalating pattern of self-harm.)

### Caremap actions

89. SO A started a caremap at the first review but added only one action: to move Mr Walker to D Wing (due to drug debts and bullying). SO A noted that Mr Walker would be referred to the substance misuse team for support, but he did not add this action to the caremap and we found no evidence that it was done. (substance misuse services, told the investigator that a referral was never received.) There was no consideration of violence reduction measures to support Mr Walker as a victim of bullying. There was also no consideration of involving Mr Walker's family in the ACCT procedures.
90. At the second ACCT case review on 29 June, staff decided to stop ACCT monitoring. Mr Walker had told staff that he was under threat on D Wing because he owed £50 but said he was 'fine' and his main concern had been to get moved from G Wing. Again, no consideration was given to violence reduction measures and no one checked to see if Mr Walker had been referred to the substance misuse team as previously agreed.

91. We consider that staff placed too much weight on Mr Walker's assertions that he was 'fine' and did not give sufficient consideration to his risk factors. This is a failing that we have commented on repeatedly in our investigations into the self-inflicted deaths of prisoners over many years.

### ***Post-closure review***

92. The post-closure review was not carried out when it should have been. PSI 64/2011, Chapter 5 states: 'The date of the first post-closure interview is a matter for the case review team to decide but must be within 7 days of closure'. Mr Walker's ACCT was closed on 29 June and the post-closure review was scheduled for seven days later, 6 July, but it did not take place until 7 July. Despite information during the post-closure period that Mr Walker was not taking his medication, was in debt on the wing and using drugs, there is no evidence anyone considered reopening the ACCT.
93. SO B said that he realised the post-closure review had been missed but he did not know why. The investigator checked the staff rota and two SO's were both on duty on 6 July and should have completed the post-closure review but could not recall why it was missed. There is no evidence that SO B considered if Mr Walker's risk had increased because he was not taking his antipsychotic medication and there is no comment on his substance misuse or debts. SO B also noted, incorrectly, that Mr Walker was due for release in September.
94. SO B gave an account of his personal circumstances during interview, when he explained why he did not complete the post-closure review to what he considered was his usual standard.

### ***ACCT documentation***

95. The ACCT documentation was incomplete. Information was not recorded on the front of the document, such as a named case manager, the date the ACCT was closed and date of the post-closure review. The information sharing agreement was not fully completed, and nor were the next of kin details. There are no risk triggers recorded and the section on the factors for the case review to consider is blank. Further, although ACCT observations were completed as required, there is little evidence that staff had any meaningful interactions or conversations with Mr Walker.
96. The Head of Safety and Equalities, said she had identified omissions in the basic information recorded and that the review when the ACCT was closed and the post-closure review were not as comprehensive as they should have been. These issues were not identified as part of the ACCT quality assurance checks.
97. We have repeatedly found that ACCT procedures are poorly managed at Pentonville. In February 2020, we recommended that the then Prison Group Director for London should write to the Ombudsman setting out what she was doing to satisfy herself that effective action was being taken to improve the quality of ACCT assessments and reviews at Pentonville. She said in response that an in-depth review of the ACCT process had taken place and that assurance checks had been introduced. However, it is clear from the failings in this case that more needs to be done. We make the following recommendation:

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

- **ensure there is a consistent case manager;**
- **consider all relevant information when assessing risk and set the frequency of observations based on the level of risk;**
- **set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk;**
- **hold a post-closure review within seven days of closure; and**
- **ensure all actions and information are properly recorded on the ACCT document.**

**The Prison Group Director for London should write to the Ombudsman by 30 June 2021 setting out what he is doing to satisfy himself that effective action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.**

## **Violence reduction**

98. A Prisons and Probation Ombudsman (PPO) publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013-2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly.
99. When he returned from Goodmayes Hospital on 22 April, Mr Walker had £801.64 credit in his private cash account. He did not work during his time at Pentonville and received 50p a day in unemployment payment, a total of £29 between 22 April and when he died. Mr Walker typically spent around £20 each week on canteen. However, on 18 June he spent £167.59, 24 June £99.80, 3 July £37.45 and 8 July £117.45.
100. There is no upper limit on the amount a prisoner can spend on canteen from his private cash. Pentonville does not currently have any measures or protocols around identifying any significant changes in canteen spends, which might highlight possible debts or bullying. The investigator tried to obtain details about Mr Walker's most recent canteen purchases, but the information was held by the contractor, DHL, who did not respond to the request. An operational support grade who has worked in the prison canteen for many years, said she has told security about prisoners requesting excessive amounts of canteen in the past, but there is no formal guidance for doing this. There was no intelligence report submitted about Mr Walker's canteen spends.
101. Mr Walker often told staff that he felt threatened, was in debt and feared for his safety. We do not know if his fears had any foundation, although his prison canteen account would suggest there was a change in his spending. Prisoners said he was trading his canteen for drugs and was being exploited by other prisoners. Mr Walker moved wings because he was in debt and his fears for his safety were highlighted as a reason for him being monitored under ACCT. When Mr Walker was discovered on 9 July, only a chair and very few personal possessions were in

his cell, another possible sign of him being in debt. There is no evidence that staff took any meaningful action to investigate and address his concerns.

102. Pentonville has a violence reduction policy dated 20 February 2020, which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation or violence. We recognise the difficulty in investigating a prisoner's unspecified fears that he is under threat. However, we are concerned that more was not done in response to Mr Walker's repeated expressions of fear for his safety due to being in debt and asking to move wings. The Head of Safety and Equalities acknowledged that violence reduction measures (Challenge, Support and Intervention Plan (CSIP)) should have been considered.
103. Staff at Pentonville hold a weekly Safety Intervention Meeting (SIM) to discuss managing the risks to prisoners and the prison. It is attended by heads of function, including security, safer custody and healthcare managers. When Mr Walker returned to Pentonville from Goodmayes Hospital he quickly found himself in debt and was supported under ACCT measures. There is no evidence that Mr Walker, despite his vulnerabilities and complex needs, was referred or considered by the SIM. This was a missed opportunity to provide him with additional support. Although Pentonville has CSIP referral guidance for staff, it was evident during interviews some staff were not sufficiently aware of how CSIP procedures should be implemented, particularly for those prisoners who are not on an open ACCT and who may require enhanced support.
104. We consider that Pentonville did not follow their own violence reduction policy. Violence reduction and the ACCT process should not be mutually exclusive, and all flags and risk factors should be considered. We make the following recommendation:

**The Governor should ensure that staff:**

- **develop a process for identifying unusual canteen spending that may indicate bullying;**
- **investigate suspected or alleged bullying in line with the prison's violence reduction policy;**
- **support victims of bullying by making CSIP referrals; and**
- **refer cases to the Safety Intervention Meeting where appropriate.**

**Change in release date - additional days awarded (ADA)**

105. Mr Walker received 117 additional days to his sentence following three separate adjudications for assaults on staff at Pentonville in September 2019. (On 4 September, Mr Walker received 35 additional days; on 18 September, 40 additional days; and on 25 September, 42 additional days. Pentonville were unable to provide copies of the adjudication documents.)
106. On 1 October 2019, on the day Mr Walker transferred to High Down, an administrator added only 35 days to Mr Walker's sentence and recalculated his release date as 21 September. The next day High Down checked Mr Walker's sentence calculation and confirmed his release date as 21 September.
107. The administrator said he received the first set of adjudication papers (35 days) just before Mr Walker was transferred, so he recalculated his release date on that basis.

He said he did not receive the other adjudication papers until after Mr Walker had transferred to High Down. He said he sent these documents by special delivery to High Down, with a note saying that Mr Walker's release date needed to be recalculated. He said High Down received the documents, but never recalculated Mr Walker's release date. The investigator was unable to establish what happened at High Down.

108. The administrator said after Mr Walker had returned to Pentonville in April 2020, he and his colleague, noticed that the additional days had not been added. The colleague contacted High Down and eventually the adjudication papers were found and returned to Pentonville in June. The administrator said he did not know who had returned the documents, but he just came into work one day and they were on his desk. On 15 June, the administrator recalculated Mr Walker's release date adding the additional 82 days, which meant Mr Walker's release date was revised to 12 December 2020.
109. The investigator was unable to establish when Mr Walker was told of his revised release date and who told him, but there was no evidence that anyone considered the impact this information might have on Mr Walker's risk. The revised release date calculation was not checked as it should have been. The administrator said his colleague was responsible for countersigning the calculation and would print off a notification letter. The administrator said he did not know why this had not been done and told the investigator that his colleague no longer worked at Pentonville.
110. The Head of Reducing Reoffending said that he took over responsibility for the OMU in March 2020. He said he had identified several issues, including that the segregation unit had not informed OMU of adjudication outcomes over a period of months, and he started an investigation. He said that processes within OMU and the segregation unit have been reviewed and revised and are now sufficiently robust to ensure a similar situation is not repeated.
111. Given that the issues have already been identified and action taken to rectify them, we do not make a recommendation.

## **Emergency Response**

### ***Body-Worn Video Cameras***

112. None of the officers who responded when Mr Walker was discovered used a body-worn video camera (BWVC). PSI 04/2017, *Body Worn Video Cameras*, states it is mandatory for staff to use BWVCs at any reportable incident (as set out in PSI 11/2012, *Management and Security of the Incident Reporting System*) and that staff should start recording at the earliest opportunity to maximise the material captured by the camera.
113. The officer said that she was focused on assisting Mr Walker. A SO said that in hindsight he should have activated his camera, but his first thought was to help Mr Walker. The PSI gives clear instructions and someone else not directly involved in helping Mr Walker should have complied with the requirement to activate their camera. We therefore make the following recommendation:

**The Governor should ensure that staff activate their BWVCs at the earliest opportunity during any reportable incident.**

## ***Delay for paramedics***

114. When the officer found Mr Walker hanging, she immediately called a medical emergency code and the control room immediately called an ambulance and the first paramedic arrived at the prison gate two minutes later. However, it was another 13 minutes before the paramedic reached Mr Walker's cell because of confusion over whether he was allowed to take his mobile phone into the prison. Although this did not affect the outcome for Mr Walker (as rigor mortis had already begun to set in when he was found), such a delay could make a critical difference in another medical emergency. We recommend:

**The Governor should ensure that there is a local emergency response protocol, agreed with the local ambulance service, so that both prison and ambulance personnel know what the logistical and operational arrangements are when an ambulance is required.**

## **Clinical care**

### ***Mental health***

115. The clinical reviewers found that the approach to Mr Walker's mental health was well structured and he was seen and assessed appropriately. Assessments by the mental health in-reach team were prompt and well documented. Mr Walker was seen regularly by his named nurse, who actively tried to encourage Mr Walker to comply with his care plan. The clinical reviewers concluded there was consistency of care provided to a good standard.

### ***Medication***

116. Mr Walker refused his antipsychotic medication (zuclopenthixol by depot injection) on 29 June, having accepted it in the previous five weeks. This medication has a half-life (the amount of time it takes for it to be reduced by half in the body) of 19 days. The clinical reviewers calculated that the dose that Mr Walker was prescribed would take around 95 days to be almost totally excreted from his body. The half-life of aripiprazole, an oral antipsychotic medication, is 75-94 hours. Mr Walker accepted this medication until two days before his death.
117. The clinical reviewers concluded that it was unlikely that missing these doses of antipsychotic medication would have had any significant impact on Mr Walker's mental health.

## **Family question**

118. Mr Walker's father asked why Mr Walker was allowed to have items he could use to self-harm.
119. There is a balance to be maintained between the interests of treatment, care, security and safety, and the decency and human rights of the person at risk. Personal items, such as clothing, shoelaces and belts, may be removed from a prisoner as part of the ACCT process where necessary. In the interests of safety prisoners may also be placed in 'special accommodation' (a cell where items such as bedding and furniture have been removed) and anti-rip clothing (special clothing made of material extremely difficult to tear into strips to create ligatures). Special

accommodation is an extreme and isolating form of custody and Prison Service policy therefore says that it must only be used as a last resort and for the shortest necessary time to prevent self-harm (that is, minutes rather than hours, according to Prison Service policy).

120. We consider that the appropriate way of managing Mr Walker's risk to himself at the time of his death would have been to support and monitor him under the ACCT process (which can include very frequent checks by staff or even constant supervision if necessary).

## **Learning lessons**

121. It is important that lessons are learned as a result of the Ombudsman's investigations. We, therefore, recommend:

**The Governor should share this report with SO A and SO B and arrange for a senior manager to discuss the Ombudsman's findings with them.**

## **Inquest**

122. The inquest into Mr Walker's death concluded in November 2023. Mr Walker's death was recorded as suicide.

**Prisons &  
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