Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andy Coath, a prisoner at HMP Pentonville, on 23 February 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T l 020 7633 4100

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

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 Andy Coath died on 23 February 2020 when he was found in his cell, having tied a ligature around his neck. It was his 50th birthday. I offer my condolences to Mr Coath's family and friends. I apologise for the delay in issuing the initial version of our investigation report.

Mr Coath was subject to self-harm and suicide monitoring (known as ACCT) for his first two weeks at HMP Pentonville. On 31 December, Mr Coath asked a supervising officer (SO) to stop ACCT monitoring. After consulting the healthcare department over the telephone, the SO closed the ACCT. Mr Coath remained in contact with the healthcare team and under the care of the psychiatrist. On 23 February, a prison officer found Mr Coath hanging in his cell.

We are concerned that ACCT procedures were ended prematurely and without the required multidisciplinary input. We note that since Mr Coath's death, Pentonville have reviewed and changed the way they manage the ACCT process.

We are also concerned that Mr Coath did not have a full reception health screen and was not offered a secondary health screen. Mr Coath's medical needs were nevertheless identified and managed by healthcare staff. The clinical reviewer considered that he received care equivalent to that which he could have expected in the community.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **December 2021**

Contents

Summary

Events

1. On 17 December 2019, Mr Andy Coath returned to HMP Pentonville after five months on bail. He was convicted of various offences and said that he intended to take his own life. Staff opened procedures to support prisoners at risk of self-harm (known as ACCT). Mr Coath saw a nurse but a problem with the electronic system meant that he did not receive a full reception health screening.

2. At an ACCT review the next day, Mr Coath said that he needed his medication. He said that he would not harm himself and that ACCT procedures should be closed but he accepted that they would remain in place until his medication issues had been addressed. Later that day, staff prescribed Mr Coath's medication.

3. The mental health team discussed Mr Coath on 31 December. They agreed that a psychiatrist should assess him.

4. That day, Mr Coath approached his wing supervising officer (SO) and asked if ACCT procedures could be closed. He was happy with his medication and said he had no thoughts or intentions of self-harm. The SO telephoned the mental health team and spoke to a nurse, who had no medical objection. The SO closed the ACCT procedures.

5. On 6 January, Mr Coath had his delayed reception health screening. He presented with unusual, intense behaviour, said he had diagnoses of mental health disorders and had previously been sectioned under the Mental Health Act. He said he had harmed himself some years previously, but said he had no current thoughts of doing so.

6. On 16 January, Mr Coath saw the psychiatrist, who found no evidence of formal thought disorder, but arranged for a further assessment. Mr Coath's care was discussed in a multidisciplinary team meeting on 4 February. He was discharged from the care of the mental health team. Mr Coath saw the prison doctor on 20 February and agreed to start a drug to treat hyperactivity and impulse control.

7. On the afternoon of 23 February, a prison officer found Mr Coath hanging in his cell. He radioed a medical emergency code and other prison staff, including nurses, provided medical aid until ambulance paramedics arrived and took over. At 4.43pm, it was agreed that Mr Coath had died.

Findings

ACCT

8. When he arrived at Pentonville, Mr Coath was appropriately identified as at risk of suicide or self-harm and ACCT procedures were started.

9. When Mr Coath asked for the ACCT to be closed on 31 December, a supervising officer closed it unilaterally, after a telephone call to the healthcare department. We consider this decision as premature and made without sufficient multidisciplinary consideration.

10. The prison told us in September 2020 that they have reviewed and revised their ACCT procedures since Mr Coath's death.

Key Worker Scheme

11. Key workers should see their allocated prisoners every week on average. Mr Coath apparently saw his key worker just once during his nine weeks in Pentonville. The prison told us that they had not fully implemented the scheme at the time due to staffing issues. Nevertheless, the lack of contact was a missed opportunity to provide meaningful support and assess his risk of suicide and self-harm.

Mr Coath's clinical care

12. The clinical reviewer said that, while there were some errors, the care provided to Mr Coath was equivalent to that which he could have expected to receive in the community.

13. Mr Coath did not have a full reception health screen when he first arrived at Pentonville. He raised this several times, but it still took three weeks to happen. He was not offered a secondary health screen.

Substance misuse

14. Mr Coath had a history of substance misuse. He was referred to the substance misuse team for support but said he did not want anything to do with them. There was no intelligence to suggest Mr Coath used drugs during his time in Pentonville. No drug traces or paraphernalia were found in his cell. At the time of issuing our initial investigation report, the post-mortem toxicology report was not available. We do not know whether Mr Coath had any illicit drugs in his system when he died.

Recommendations

- The Governor should share this report with SO A and discuss the Ombudsman's findings with him.
- The Governor should ensure that key workers are allocated sufficient time for delivery of the key worker role, which includes individual time with each prisoner.
- The Head of Healthcare should ensure that all new prisoners receive a full reception health screening and are offered a secondary health screen.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. There were no responses.

16. The investigator visited Pentonville on 3 March 2020. He obtained copies of relevant extracts from Mr Coath's prison and medical records. He viewed body-worn video camera footage of the emergency response and listened to the radio traffic recordings. E Wing, where Mr Coath lived, is not covered by CCTV. Due to an administrative error, Pentonville had not recorded Mr Coath's telephone calls, so he was not able to listen to them.

17. The investigator interviewed eight members of staff and a prisoner at Pentonville. NHS England commissioned a clinical reviewer to review Mr Coath's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

18. We informed HM Coroner for London Inner North of the investigation. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Coath's mental health advocate, who was acting as his next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They had no specific issues about Mr Coath's treatment in prison.

Background Information

HMP Pentonville

20. HMP Pentonville is a local prison in London that holds around 1,200 young adult and adult men. 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. There is a substance misuse team, a pharmacy, and a Health and Wellbeing Team. There is also a subcontract for Building Futures, a charity that provides substance misuse support.

HM Inspectorate of Prisons

21. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Pentonville in April 2019. Inspectors said that the management of ACCT support processes remained weak and was generally managed poorly. They reported that in many ACCT documents care maps were inadequate, there was no continuity of case ownership and limited multidisciplinary involvement in case reviews.

22. 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. Inspectors found that drugs remained hugely problematic at the prison.

23. Inspectors reported that there was sound governance of healthcare, that staffing levels and skills mix were sufficient, that there had been demonstrable learning from deaths in custody and regular sharing of health information between specialist teams at the Health and Wellbeing referral meetings.

24. Reporting on previous deaths at the prison inspectors raised concerns that while PPO recommendations relating to healthcare had been met, most of the other PPO recommendations had not been.

25. In an independent review of progress in February 2020, inspectors found that since the last inspection there had been no meaningful progress in achieving the PPO recommendations. Nor had there been progress on inspectors' previous findings on ACCT management. The review found, however, that good progress had been made in tackling the significant drug problem.

Independent Monitoring Board

26. 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 2020, the IMB reported that incidents of self-harm had risen, as had the number of ACCTs opened. A reorganisation in December 2020 of how vulnerable prisoners were managed led to a reduction in the number of ACCTs in place. There had been problems in operating the key worker scheme due to staffing pressures. The Board also noted that secondary health screens were not always held within the proper timeframes.

Previous deaths at HMP Pentonville

27. Mr Coath was the ninth Pentonville prisoner to die since the beginning of 2018. Five of the previous deaths were self-inflicted, two were due to natural causes, and one was due to drug use. There has since been a further self-inflicted death.

28. We have previously made recommendations about identifying risk of self-harm in reception and the quality of ACCT procedures. Following a previous investigation into a self-inflicted death in August 2019, the prison told us in September 2020 that they have reviewed ACCT procedures, including training and support for ACCT managers, and have established a single point of contact to coordinate healthcare representation at ACCT reviews.

Assessment, Care in Custody and Teamwork

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.

The key worker scheme

30. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:

    - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
    - Key workers must have completed the required training.
    - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

31. Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

32. Mr Andy Coath was remanded to HMP Pentonville in July 2019 and released on bail a month later.

33. This was not his first time in prison. He had a history of mental health problems, including bipolar affective disorder, adult attention deficit hyperactivity disorder (ADHD) and had been diagnosed with Asperger syndrome. He had been sectioned under the Mental Health Act in 2014. He had a history of harassment towards his local authority and mental health trust. He believed that he had a number of mental illnesses that medical professionals would not accept. Mr Coath said that he used strong cannabis on a daily basis.

December 2019

34. On 17 December, Mr Coath was convicted of various offences, including racially aggravated harassment, and sentenced to 18 months imprisonment. He was taken back to Pentonville. The Person Escort Record (PER) that accompanied him to prison from court included a suicide and self-harm warning form noting that Mr Coath said that he intended to take his own life that day by hanging himself.

35. In reception, Mr Coath said that he would not get the medication he needed in prison and intended to hang himself that evening. Staff opened ACCT procedures. A supervising officer (SO) completed the Concern and Keep Safe form and noted that Mr Coath suffered from bipolar disorder. The Immediate Action Plan noted that Mr Coath was still waiting to see a nurse in reception. Officers were to check on him at least once per hour.

36. A nurse saw Mr Coath. He was an agency nurse who usually worked at a different prison. Although he could access Mr Coath's medical record, he did not have access to Pentonville's standard electronic reception process. The nurse noted that Mr Coath had Asperger syndrome, suffered from anxiety, and had been prescribed pregabalin (anti-anxiety medication) in the community. He noted that Mr Coath was subject to ACCT monitoring, but that Mr Coath said he had no thoughts of self-harm. He referred Mr Coath for a mental health assessment.

37. Mr Coath refused to engage with the cell sharing risk assessment (CSRA) interview or with his first night in custody interview. An officer conducted an ACCT assessment interview the next day, on 18 December. Mr Coath was still reluctant to speak to an officer and denied having said he was going to hang himself. He said he did not want to be subject to ACCT monitoring. He said that he wanted to see a doctor.

38. A SO chaired an ACCT review with Mr Coath, an officer and a psychiatric nurse from the mental health in-reach team. Mr Coath said that the in-reach team had not helped him the last time he had been in prison, so he did not expect them to help him now. He was angry that he had not seen a doctor the previous night and said he was suffering without his medication. The nurse said that he would sort out his medication with the prison doctors.

39. Mr Coath said that other than his medication, he had no issues and did not want to be under ACCT management. He did not like staff turning his light on during the

night as it woke him up. The SO explained that the ACCT would remain in place until the issue with his medication had been resolved. In the meantime, staff would check on him at least every two hours, with conversations morning and afternoon. Mr Coath's risk was marked as low, and the next review was scheduled for 3 January. The caremap noted the issue with his medication and that the psychiatric nurse would address this. The psychiatric nurse noted this on Mr Coath's medical record and that day a nurse prescribed him pregabalin.

40. Mr Coath's medical record noted that he had complained to the prison's Safer Custody department that he had not had a reception health screen.

41. On 27 December, a worker from the Health and Wellbeing Team sent Mr Coath a letter providing him with a self-referral form for structured group work. This would allow them to make a decision as to which support group, if any, would be most appropriate for him.

42. A note on Mr Coath's NOMIS prison record on 29 December showed that he had been given two warnings under the Incentives and Earned Privileges (IEP) scheme (designed to encourage and reward good behaviour). He risked being downgraded to the basic level, thereby losing privileges (including access to a television and time out of cell to socialise with other prisoners).

43. On 30 December, the psychiatric nurse assessed Mr Coath's mental health. He recorded that Mr Coath was a little agitated and said that he had not received the mental health support he needed. He wanted to see a psychiatrist to discuss medication. He wanted a transfer to a different prison. He told the nurse that he was having trouble sleeping. The nurse noted on Mr Coath's medical record that he would inform the primary care team that Mr Coath should have a reception health screen that afternoon, and that the healthcare multidisciplinary team meeting the following day should discuss Mr Coath's ongoing mental health care.

44. On 31 December, a volunteer member of the chaplaincy team recorded that he was concerned about Mr Coath's mental health. He said he had written to the mental health team setting out his concerns.

45. At a mental health in-reach team meeting on 31 December, it was agreed that Mr Coath should be reviewed by a psychiatrist because of his Asperger's diagnosis. He was also referred for a speech and language therapist assessment and the team recommended that Mr Coath be allocated a single cell.

46. Also, that day, Mr Coath went to the wing office and asked SO A if the ACCT procedures could be closed. Mr Coath said that they were not necessary, and he was aggravated by checks during the night. He said he was happy with his medication and had no thoughts of self-harm. SO A noted that Mr Coath had a cellmate, which was a protective factor (though he also noted that Mr Coath wanted a single cell).

47. SO A recorded on the ACCT form that he had spoken to a nurse from the mental health in-reach team on the phone and that she had said that Mr Coath would see a psychiatrist in the New Year, though no appointment had yet been made. SO A noted that Mr Coath was taking his medication, and that the nurse had no objection to ending ACCT monitoring. He concluded that Mr Coath's risk had reduced, and he closed the ACCT. He set the post-closure review for 7 January.

48. At interview SO A said that his discussion in the office with Mr Coath "became an ACCT review really". He said he thought that being checked at night was likely to lead to confrontations with staff which would be bad for Mr Coath's mental well-being.

49. He said he was aware that Mr Coath had mental health issues so he telephoned the nurse and said that he had just had a conversation with Mr Coath and they had "sort of … come to the conclusion that we'd close his ACCT", but that he would not close it if she objected. He said he did not have a long conversation with the nurse and that he did not get the impression that she consulted Mr Coath's medical notes, but that she was speaking from her knowledge of him, and that she raised no objections to closing the ACCT. He said that even though the ACCT review was not multidisciplinary in the sense that healthcare was in attendance, he had "sort of consulted them before making the final decision".

50. SO A also said that he regarded the ACCT care map actions as closed because Mr Coath told him he now had the medication he wanted. He said that he therefore considered that Mr Coath's risk had lowered to a point where he maybe still needed support but did not require ACCT supervisions.

51. The nurse told the investigator that she did not remember the conversation with SO A. She made no record of it in Mr Coath's medical record.

January 2020

52. On 6 January, Mr Coath had his delayed reception health screen. The nurse described his behaviour as unusual and intense. Mr Coath explained his mental health diagnoses and said he had previously been sectioned under the Mental Health Act and had harmed himself some years previously, but that he had no current thoughts of doing so. He said he used marijuana regularly. The nurse referred him to the Health and Wellbeing Team, who discussed Mr Coath the next morning. They noted that he was scheduled to see the psychiatrist on 16 January and that he had been referred for assessment with a speech and language therapist.

53. SO A held an ACCT post-closure interview with Mr Coath on 10 January. He recorded that Mr Coath was pleased to have been assessed as high risk for cell-sharing. He said he had no contact with his family but had been talking to a fellow prisoner, which had helped him. He concluded that the ACCT could remain closed.

54. On 16 January, Mr Coath saw a psychiatrist. He recorded that Mr Coath was hyperactive and animated during the consultation. The psychiatrist found no evidence of formal thought disorder and concluded that, while Mr Coath had some paranoid ideas, he was not delusional. There were possible signs of autism and features of personality disorder. He told Mr Coath that he would arrange for a further assessment. In the meantime, he suggested that Mr Coath attend a weekday support group for prisoners with mental or physical healthcare needs (known as the Day Care Centre) to structure his time. It would also allow healthcare staff to assess his mental health issues.

55. At the Health and Wellbeing team meeting the following morning, it was agreed that the mental health team would make an ADHD assessment, and Mr Coath would be referred to the Wellbeing Centre (an occupational therapy-led day service). On 24

January, the referral was refused because of Mr Coath's hostility. Healthcare staff sent a self-referral form to Mr Coath encouraging him to apply for psycho-educational group therapy (educating people about their disorders and ways of coping).

56. On 28 January, an officer saw Mr Coath apparently sleepwalking. A nurse went to his cell to assess him. His cell was untidy and strewn with newspaper and food, and he had written abusive words on the walls. He had moved his mattress from the bed to the floor to sleep on. He was staring into space and appeared vague and dishevelled. Later that day, a psychiatric nurse went to Mr Coath's cell to assess him. Mr Coath was agitated and angry but was happy to speak to him. He said that he had been misdiagnosed over a number of years and was angry at the medical sector. He said that officers did not understand his problems. The nurse noted that mental health staff should continue to monitor him.

57. On 31 January, Mr Coath submitted an application for a day-care self-referral form, commenting "I've lost my mind". This was discussed at the Health and Wellbeing Team meeting and they made an appointment for him to see a psychiatrist on 20 February. There is no record that the team considered Mr Coath's risk to himself at this meeting.

February 2020

58. Mr Coath's care was discussed in the multidisciplinary mental health team meeting on 4 February. He was not deemed suitable for the Day Care Centre because of his anger. He was due to have a psychiatric review, including consideration of ADHD, on 20 February. An entry on his medical record noted that he was discharged from the care of the in-reach team.

59. Mr Coath graffitied his cell on 5 February. He was given a welfare call to his mental health advocate (probably because he had no credit on his telephone account, although the prison was unable to confirm the reason). His key worker (a prison officer who is the first port of call for any questions or issues the prisoner may have) tried to speak to him, but Mr Coath did not want to. He wanted a transfer to a different prison, but this could not happen until his categorisation process was complete. The key worker said she would look into this. This is the only recorded contact that Mr Coath had with his key worker during his time at Pentonville.

60. On 7 February, Mr Coath agreed to clean and repaint his cell, and accepted help to do so.

61. On 20 February, a psychiatrist assessed Mr Coath's mental health. The psychiatrist noted that Mr Coath said he had not been taking ADHD medication for two years due to a number of issues but would like to start treatment again. He said he was not taking illicit drugs. The psychiatrist encouraged Mr Coath to start a low dose of Concerta (a drug for hyperactivity and impulse control) which would be raised slowly. He said he would ask about Mr Coath undertaking group work and would review him in two to three weeks.

Events of 23 February

62. A prisoner who was a friend of Mr Coath's told the investigator that he had noticed that Mr Coath's behaviour seemed slightly erratic in the days leading up to his death. However, he described him as composed when he saw him on the morning of 23 February. Prisoners collected their cooked lunches at approximately 12.30pm and went back to their cells.

63. At about 3.50pm that afternoon, an officer took Mr Coath's evening meal to his cell but realised that Mr Coath was a vegetarian and he had been given the wrong meal. He called through the door to ask Mr Coath which meal he would prefer, but Mr Coath did not answer. He could not see Mr Coath, so went into the cell. He moved a sheet from the bed and found Mr Coath with a ligature made from a torn bed sheet around his neck, tied to the bed. He radioed a code blue emergency (meaning a prisoner is unconscious or having difficulty breathing) and used his anti-ligature knife to cut the ligature. He could not find a pulse. Another officer arrived, and they moved Mr Coath to the centre of the cell and began cardiopulmonary resuscitation (CPR).

64. The code blue radio call was made at 3.54pm and prompted the control room to call an ambulance. The ambulance service records show that they received the call at 3.56pm.

65. Other staff responded to the emergency call, and a SO arrived at 3.56pm and switched on his body-worn video camera. Three nurses arrived at 3.58pm and took over CPR from the officers. They applied a defibrillator, but there was no pulse and it advised them to continue with CPR. The nurses continued providing emergency aid to Mr Coath until paramedics arrived. Together they continued to try to revive Mr Coath until, at 4.43pm, they agreed that he had died.

Contact with Mr Coath's next of kin

66. Mr Coath had not given the prison details of his next of kin when he arrived. The Probation Service provided contact details for Mr Coath's mental health advocate, whose address Mr Coath had given as his release address. The prison's family liaison officer went to this address and broke the news to the advocate. The advocate told the FLO that Mr Coath's mother had died some years previously and that he had had no contact with his father or his siblings for a number of years. In line with Prison Service guidance, Pentonville offered a contribution to the costs of Mr Coath's funeral.

Support for prisoners and staff

67. After Mr Coath's death, the duty governor debriefed the staff involved in the emergency response, including healthcare and ambulance staff, to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

68. The prison posted notices informing other prisoners of Mr Coath'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 Coath's death.

Post-mortem report

69. At the time of issuing our initial report, post-mortem reports were not available.

Findings

Management of risk of suicide and self-harm

70. When Mr Coath arrived at Pentonville on 17 December, he was appropriately assessed as needing the support of ACCT procedures, and they were opened. We are, however, concerned about the decision to stop ACCT monitoring on 31 December.

71. PSI 64/2011, Safer Custody, contains guidance on the operation of ACCT. The PSI requires case reviews to be multidisciplinary where possible. SO A said that he spoke on the phone to a nurse in the mental health team, who confirmed that there was no reason not to close ACCT procedures. In interview, the nurse said that she did not recall the conversation. There is no note of this conversation in Mr Coath's medical record.

72. We have repeatedly said over many years that it is important that staff consider a prisoner's risk factors for suicide and do not simply rely on what a prisoner says about his intentions or how he presents. In this case, Mr Coath had a number of risk factors, including a history of mental illness, substance misuse and previous suicide attempts. In addition, Mr Coath was still under the care of the mental health team and had an appointment with a psychiatrist pending. We have seen no evidence that SO A gave these risk factors sufficient consideration.

73. We are also concerned that SO A closed the ACCT after what amounted to an informal discussion between himself and Mr Coath. Although we accept that he spoke to a nurse, this appears to have been a brief, informal conversation and neither she nor wing staff were involved in a formal multi-disciplinary case review discussion about the pros and cons of closing the ACCT before Mr Coath had seen the psychiatrist. His unilateral decision to close ACCT procedures was not in line with the requirement of a multidisciplinary case review set out in the PSI.

74. We do not say that it was necessarily inappropriate to have closed the ACCT on 31 December, but we consider that the decision to do so was not made in an appropriate way.

75. We have previously made recommendations to Pentonville about the operation of the ACCT process, when we considered ACCT procedures to have been prematurely closed and without proper multidisciplinary consideration. These are the same issues that cause concern here. Since Mr Coath's death Pentonville have told us that they have reviewed ACCT procedures, including training and support for ACCT managers, and have established a single point of contact to coordinate healthcare representation at ACCT reviews. We therefore make no recommendations, although we will expect to see improvements in future cases.

76. We make the following recommendation:

The Governor should share this report with SO A and discuss the Ombudsman's findings with him.

77. We are also concerned that there is no evidence that any thought was given to re-opening the ACCT in the light of Mr Coath's subsequent behaviour. For example:

- 31 December - on the afternoon that the ACCT was closed, a chaplain expressed concern that Mr Coath was finding it hard to cope with his mental condition;
- 6 January - a nurse described his behaviour as “unusual and intense”;
- 16 January - a psychiatrist described him as “hyperactive and animated” with some paranoid ideas and referred him for a further psychiatric assessment;
- 27 January – he was racially abusive to staff, threw things around his cell and damaged his observation panel;
- 28 January - he was seen apparently sleepwalking, his cell was strewn with newspapers and food, he had written abusive words on the walls and had moved his mattress from the bed to the floor, and he was staring into space and appeared vague and dishevelled;
- 31 January – he applied for a day-care support place, saying he had lost his mind.

78. In addition, SO A said he was concerned that Mr Coath was frustrated because he wanted to move out of Pentonville but could not do so until he had been categorised (which seemed to be taking an unusually long time).

79. Again, we do not say that the ACCT should necessarily have been opened, but we are concerned that it was not considered. For example, when Mr Coath’s application for a day-care support place was discussed by the Health and Wellbeing Team on 31 January, there is no record that they considered his risk to himself.

Key Worker Scheme

80. In line with national guidance, key workers should see their allocated prisoners at least weekly on average. The purpose of the key worker scheme is to give each prisoner a point of contact who will meet them regularly to help and support them. Mr Coath apparently only saw his key worker once during his nine weeks at Pentonville. Pentonville pointed out that due to staffing issues they had not fully implemented the key worker scheme at the time of Mr Coath’s death. Even so, we would have hoped to see evidence of meaningful interaction with a prisoner who had recently been under ACCT management. This was a missed opportunity, both to assess his risk of suicide and self-harm, and to provide him with any support he might have wanted. We, therefore, recommend:

The Governor should ensure that key workers are allocated sufficient time for delivery of the key worker role, which includes individual time with each prisoner.

Mr Coath’s healthcare

81. The clinical reviewer said that the care provided to Mr Coath was broadly equivalent to that which he could have expected in the community. The care offered to him was detailed and focussed on his needs. He had complex mental health issues, and the review by the mental health team was timely. He had been seen by a

psychiatrist three days before he died. It was a positive meeting, with plans for ongoing support and medication.

82. Mr Coath did not receive a full reception health screen. He raised this several times before it was completed on 6 January. Although the clinical reviewer noted that this did not significantly impact on his care, it should not have happened.

83. All new prisoners should also be offered a secondary health screen. Mr Coath was not. We make the following recommendation:

The Head of Healthcare should ensure that all new prisoners receive a full reception health screen and are offered a secondary health screen.

Substance misuse

84. When Her Majesty's Inspectorate of Prisons inspected in Pentonville in April 2019, they noted that the availability and use of drugs were a problem for the prison. Pentonville introduced a new drug strategy, and in a review of progress in February 2020, inspectors noted good progress in addressing the problem.

85. Mr Coath had a history of substance misuse. He was referred to substance misuse services but said he did not want anything to do with them. A drugs worker said that drugs were available on the wing, but he did not think Mr Coath was using drugs. There was no intelligence that Mr Coath used drugs during his time in Pentonville. No drug traces or paraphernalia were found in his cell. Post-mortem tests were not available at the time of publication, so we do not know if Mr Coath had taken any illicit drugs before he died.

Inquest

86. At the inquest, held from 5 to 13 February 2024, the jury reached a narrative conclusion that Mr Coath took his own life and intended to do so.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T l 020 7633 4100