

**Investigation into the death of a man
whilst in the custody of HMP Pentonville
in March 2012**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2013

This is the report of an investigation into the death of the man at HMP Pentonville in March 2012. The man was found in the early hours of the morning hanging from his cell window bars. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to conduct a clinical review. Pentonville co-operated fully with our enquiries.

On his remand into custody, the man reported that he had been treated for schizophrenia for which he was prescribed an antipsychotic medication. He had taken the medication for a number of years but a prison doctor decided to stop the prescription because he did not display any symptoms of psychosis. This decision appears to have been appropriate. In the months before his death, he was held in three separate London local prisons where he was assessed regularly by psychiatrists and mental health teams all of whom concluded he showed no active signs of mental illness. The clinical review concludes that, for the most part, his treatment was good the man was dependent on alcohol for which he received an appropriate clinical detoxification but this was not backed up by structured psychosocial support.

The man was convicted of a further offence two weeks before his death, for which he was facing a lengthy sentence, but his risk was not reviewed by staff as it should have been when he got back to the prison. Nevertheless, he was seen not long after by a psychiatrist who did not identify any concerns that the man was at risk of suicide and self-harm. I am therefore satisfied that there was little evidence to suggest that his death could reasonably have been foreseen.

However, I am concerned that so little appears to have been known about the man by staff at Pentonville. In addition, after the man was found hanging, the emergency response was not as swift as it should have been. While this did not affect the outcome in his case, there is a need for Pentonville to revise emergency procedures to ensure there is no unnecessary delay in future incidents.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

January 2013

CONTENTS

Summary

The Investigation Process

HMP Pentonville

Key Events

Issues

Conclusion

Recommendations

SUMMARY

1. On 14 November 2011, the man was remanded into custody at HMP Brixton. The man told a nurse that he had been diagnosed with schizophrenia some years previously for which he had been receiving treatment from his doctor. Over the following days he received a clinical alcohol detoxification and was assessed by members of the prison's mental health team and a psychiatrist who concluded that he showed no signs of psychosis.
2. In early December, the man was assessed by another prison psychiatrist who also concluded that he had no overt psychotic symptoms. The psychiatrist postponed the issue of the anti-psychotic medication the man had received in the community and recommended close monitoring by the prison's mental health in-reach team.
3. The man transferred to HMP Wandsworth on 19 December 2011. During the reception process he was referred for an assessment by the mental health team and continued to receive further clinical psychiatric care and monitoring. During his time at both Brixton and Wandsworth, he said he had no thoughts of suicide or self-harm.
4. On 24 January, the man arrived at HMP Pentonville. Following a mental health assessment, he was referred to one of the prison's psychiatrists and the mental health team. Healthcare staff were aware of his history of schizophrenia, but found no evidence of psychosis or other mental illness. During an assessment with the prison psychiatrist at the end of February, the man said he had not experienced any recent symptoms of psychosis and that he was feeling better without his medication.
5. The man was convicted of wounding with intent to cause grievous bodily harm (GBH) on 7 March, but was not assessed by a member of healthcare staff when he got back from court to check how this had affected him. On 26 March, the prison psychiatrist assessed the man and had no concerns that he was at any immediate risk of suicide and self-harm and he showed no signs of depression. During an early morning roll check in March, the man was found hanging in his cell, and it was evident that he had been dead for sometime.
6. The review into the medical care received by the man concludes that he received prompt assessments and reasonable interventions while in the care of each of the prisons in which he stayed. The clinical reviewer makes two recommendations about retrieving medical records from the community and the treatment of substance misuse.
7. We are concerned that the man's risk when he returned from court was not reviewed in line with national requirements. We also make a number of recommendations about the delay in calling an ambulance, operation of the prison personal officer scheme and the recording of entries in prisoner records.

THE INVESTIGATION PROCESS

8. The investigator carried out the investigation. He spoke to the Deputy Governor of Pentonville, on the day the man died to request information. He visited the prison on 3 April and met the Duty Governor, Head of Safer Custody and a member of the Independent Monitoring Board (IMB). (IMBs consist of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained.)
9. Notices about the investigation were posted in the prison asking staff and prisoners who had information relevant to the investigation to contact the investigator. No one came forward.
10. HM Coroner for Inner North London was informed of the investigation. A copy of the investigation report will be sent to the Coroner.
11. A clinical reviewer was appointed to review the clinical care that the man received while he was in prison. The clinical reviewer received copies of all relevant medical and prison documentation relating to the man. The clinical review was received on 22 July.
12. The investigator was shown the wing and cell where the man spent the last days of his life, as well as visiting other areas of the prison. He reviewed the man's records and conducted interviews with staff at Pentonville. He also interviewed healthcare staff at Brixton. The clinical reviewer joined the investigator for interviews with healthcare staff. During the investigation the investigator provided verbal feedback which was followed up in writing to the Governor of Pentonville.
13. One of the Ombudsman's family liaison officers contacted the man's mother to tell her about the investigation. The man's mother asked that the investigation address the following points:
 - Her son had telephoned her two days earlier when he seemed jovial and was looking forward to coming home. The man's mother wanted to know what happened to her son between this time and his death two days later.
 - The man's mother sought clarification about her son's movements on the day of his death and asked what checks were made on her son the night before he was found.
14. The man's family received a copy of the draft version of the report as part of the consultation period. The man's family told my family liaison officer that they had found the report informative but raised a number of areas of concern. These included that they were shocked to learn that the man was not checked between 9.00pm until he was found. The family remained unhappy with the actions of prison officers in general. They were also concerned to learn of the delay in accessing keys to the prison gate and welcomed the recommendation with regard to this. We have considered the issues raised and although the comments have led to no changes in the investigation report, we have sought to address

the comments where appropriate in separate correspondence to the man's family.

HMP PENTONVILLE

15. HMP Pentonville is a local prison serving the courts of north London and holds over 1300 prisoners.
16. Whittington Health, Camden & Islington NHS Foundation Trust, and Barnet, Enfield and Haringey NHS Mental Health Trust provide health services, including substance misuse, mental health and psychiatric care.

HM Inspectorate of Prisons (HMIP)

17. HM Inspectorate of Prisons conducted an unannounced inspection from 24 February to 4 March 2011. HMIP noted that Pentonville had a large and transient prison population, and its prisoners had some of the highest incidence of mental ill health and substance misuse of any local prison in the country.
18. Inspectors said that the reception area of the prison "... remained immensely busy and staff had little time to address all the immediate issues presented by prisoners". They judged that relationships between staff and prisoners were satisfactory, but there was no effective personal officer scheme and too few prisoners were aware that they had an allocated personal officer. The Inspectorate recommended that each prisoner should have a designated personal officer responsible for checking regularly on their individual welfare, dealing with issues as they arise and helping to ensure their identified integration needs were met. Primary mental health services were regarded as needing development but secondary services were seen as well structured to meet the needs of prisoners.

Independent Monitoring Board (IMB) Report

19. In its 2010/11 report for Pentonville, the IMB commented that reception procedures were compromised by the number of prisoners going through reception at one time. Despite these strains, the IMB were satisfied that prisoners were treated with respect, and that relationships between staff and prisoners remained good.
20. The IMB repeated a previous recommendation to introduce an effective personal officer scheme. This scheme had still not been implemented at the time of the man's death.

Previous self inflicted deaths at HMP Pentonville

21. The man's death is the seventh apparent self-inflicted death at Pentonville since January 2010. There are no direct similarities between the findings of these investigations and that of the man.

KEY EVENTS

22. The man had a number of previous convictions for offences against the person and property, theft, public order and for being drunk and disorderly. He had been in prison before. The man was arrested in June and again in September. He was not remanded in custody and he was arrested for disorderly behaviour in October, and failed to appear at court in relation to ongoing criminal proceedings in November.
23. In November, the man was arrested and charged. The Metropolitan Police custody risk assessment, completed in the early hours of 13 November, recorded that the man was under the influence of alcohol at the time of his arrest. He told police that had been diagnosed with schizophrenia for which he was receiving treatment. He said he was up to date with his medication, but was due to take it again that night. He said that he had never tried to harm himself. The man asked to see a doctor but the police decided that he did not need to see one. He was checked every 30 minutes.

HMP Brixton

24. On 14 November, the man was taken from Shoreditch police station to Thames Magistrates' Court. Later that day he was remanded into the custody of HMP Brixton arriving shortly after 5.00pm.
25. Nurse A, a Registered Mental Nurse (RMN) at Brixton, assessed the man as part of a routine first night reception health screen. The man told the nurse that he had a fractured thumb, for which he had an appointment at University College Hospital (UCH) on 18 November. He also had an ankle and jaw injury which had been treated the previous year. He said that he did not use recreational drugs but drank five cans of high alcohol lager daily and suffered from stomach ulcers and occasional chest pain.
26. The man told the nurse that he had been diagnosed with schizophrenia, for which he was being treated by his general practitioner (GP) with olanzapine. (Olanzapine is an antipsychotic drug, which reduces the typical symptoms of schizophrenia.) The man said that he had spent time in the Royal Free Hospital in 1997 for mental health treatment. The nurse noted that, although the man said he felt slightly depressed as a result of being in prison, he did not have any thoughts of harming himself. The nurse referred the man to the doctor and for a mental health assessment. The nurse obtained the details of his GP, in order to confirm his medical history and prescriptions. (He faxed a request for a detailed summary of the man's medical history and medication on 16 November.) The nurse told the investigator that at the time of his assessment he was more concerned for the man's physical health than his mental health.
27. Later that evening, the man was seen by prison Dr A at Brixton. The doctor noted that the man was receiving treatment at University College Hospital for injuries to his wrist and jaw. The doctor prescribed a low dose of Librium to treat his alcohol withdrawal and requested his hospital appointments be followed up

by healthcare staff.

28. The following day, 15 November, the man was assessed by the prison's mental health team. Nurse A conducted the assessment and found that the man was very talkative about the circumstances surrounding the alleged GBH against his female friend and seemed to be engrossed in his upcoming court case. The man told the nurse about his alcohol dependence and his diagnosis of schizophrenia in 1997, but said he had never experienced any auditory or visual hallucinations. He said that he was discharged from the Royal Free Hospital with a prescription of olanzapine which he said kept him calm and his GP had continued the prescription. The man said that he had never had any contact with community mental health teams, which the nurse found surprising. He denied any thoughts of harming himself and said he was not feeling depressed. The nurse recorded that he did not have any psychotic symptoms.
29. The same day, he was seen by a member of the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) as part of his induction. CARATs provide psychosocial support to prisoners dependent on alcohol and other substances. He told the CARATs worker that he last drank on 12 November, and a care plan was opened, whereby the man was required to attend eight drug awareness group work sessions.
30. The man was discussed at the prison's mental health team meeting the next day, 16 November. Dr B, a psychiatrist, noted that the man was going through alcohol detoxification and was no longer prescribed olanzapine. The meeting noted that the man had no previous history of community mental health involvement or admission to hospital (despite his account of a stay at the Royal Free). The team noted that although there were no clear signs of mania or psychosis, the man was preoccupied by his offence. It was agreed that the man would be discussed again at the next mental health team meeting once his GP records had been received, and that he would benefit from a further assessment following his detoxification.
31. On 21 November, the man completed his alcohol detoxification programme. It was noted that he displayed no signs of withdrawal and appeared alert and responsive. Later that day records were received from the GP, which confirmed the man had last been prescribed a number of medications on 3 November, including olanzapine and zopiclone used for the treatment of insomnia. There was no information about his admission to the Royal Free for mental health treatment.
32. On 29 November, the man attended the fracture clinic at University College Hospital and was discharged. Dr A recorded that the man continued to complain of pain in his jaw, wrist and ankle and prescribed a course of painkillers.
33. Nurse A saw the man again on 2 December, and said he was settled, calm and pleasant and that he said he had no thoughts of harming himself. The nurse reported that there was no evidence of either psychotic or depressive symptoms, but that the man continued to complain of shoulder and jaw pain. The nurse discussed with Dr A that the man had not been prescribed any olanzapine for

four weeks, (although he said he was still taking it until 11 November). It was agreed that as the man's presentation remained stable he would continue not taking olanzapine and would be discussed again at the next mental health meeting.

34. On 6 December, the man appeared at the City of London Magistrates' Court. The man was told that he was to appear again in front of the court on 19 December.
35. The man was discussed again at the mental health team meeting on 8 December, when it was agreed he needed a psychiatric assessment. The man attended a group work session with CARATs the same day, and he was frustrated about the pain in his jaw and his medication. On 13 December, he was seen by psychiatrist, Dr C. The man talked of his offence and the stresses of the previous two years. The doctor noted that, when asked about his mental illness, the man did not describe any psychotic symptoms. The man told the psychiatrist that he took olanzapine because, "he had been told to". The doctor noticed that the records from the man's hospital admission for mental health treatment had not been retrieved and wrote to the PCT requesting the records.
36. Dr C concluded that as the man exhibited no overt psychotic symptoms any further prescription of olanzapine would be postponed, but should be offered again if there was any indication of a relapse or evidence of psychosis. The psychiatrist decided that the man should also no longer receive zopiclone, but he prescribed promethazine, an antihistamine. The doctor recommended that the man should be monitored by the mental health team, which was agreed at the next mental health team meeting on 15 December.
37. On 19 December, the man was sentenced by the City of London Magistrates' Court on 5 June and for failure to surrender to police bail on 8 November. He received a sentence of 70 days imprisonment and was taken to HMP Wandsworth.

HMP Wandsworth

38. Nurse B at Wandsworth completed a reception health screen at Wandsworth on 19 December. She noted the man's previous mental health treatment at Brixton and that he had not taken olanzapine for some time. The nurse referred him to the primary mental health team and the doctor. She recorded that he expressed no thoughts of harming himself.
39. Later that day, the man was assessed further by a nurse manager. The man told the nurse he was anxious about being at Wandsworth, as he had just settled at Brixton and built up a good relationship with the psychiatrist there. The man told the nurse manager that he had been diagnosed with schizophrenia and was tearful but talkative during the assessment. The nurse manager continued the man's prescription from Brixton.
40. The following day, 20 December, the man was assessed again and told Practice Nurse A that he wanted to return to Brixton, he did not mention any other

concerns. Healthcare staff at Brixton wrote to the mental health team at Wandsworth to advise that the man would require further assessment and agreed to forward Dr C's report. They also told Wandsworth that Dr C had requested records about the man's admission to hospital in 1997.

41. On 22 December, a Community Psychiatric nurse from the Wandsworth mental health team assessed the man. He noted that the man was not willing to explore any mental health issues, and told him that he was fine and did not have any thoughts of harming himself. After the interview, the Community Psychiatric nurse advised the wing senior officer that if there were concerns about the man's mental health, staff should contact the mental health team. The Community Psychiatric nurse made an appointment for the man to be seen by the prison doctor, agreed that he should be monitored by the mental health team and that community mental health records should be retrieved.
42. On 11 January 2012, the man was again seen by Nurse C at Wandsworth from the mental health team, who reported that he was alert and talkative, but angry that he was not receiving the same painkillers that he had had at Brixton. He denied any thoughts of harming himself and exhibited no signs of serious mental illness.
43. The man's solicitors visited the man on 16 January. She told the investigator that during her meeting with the man his behaviour caused her great concern. She said he was erratic, appeared distressed and had difficulty communicating with her. She told the investigator that the man had said that his olanzapine had been stopped while he was at Brixton. The solicitor wrote to the prison on 19 January with her concerns and requested that her client be referred to the mental health team. (By the time the letter was received on 24 January, the man had transferred to Pentonville and had been referred to the mental health team there.)
44. Later that day the man was seen again by Nurse C, who was unaware of his solicitor's concerns and concluded that there were no indications to suggest that he should continue to be seen by the mental health team. He was therefore discharged from their care.
45. On 24 January, the man appeared at Snaresbrook Crown Court and was remanded to HMP Pentonville. (It is usual in London for prisoners to be taken to the prison closest to the court in which they are to appear.)

HMP Pentonville

46. When he arrived at Pentonville, in January, Healthcare Assistant A completed the first reception health screen. The man told the nurse that he had been diagnosed with schizophrenia for which he had previously been prescribed olanzapine. The man expressed no thoughts of harming himself.
47. Later that evening, Dr A at Pentonville examined him and recorded that the man showed no obvious signs of either depression or schizophrenia, but that at times

during her assessment he appeared agitated. The doctor referred the man for assessment by the primary mental health team.

48. On 26 January, the man was seen by Community Psychiatric Nurse, A at Pentonville. He told the nurse that he had been taken off olanzapine while at Brixton, which he said had previously been prescribed by his GP. The man said he did not hear voices, but said he had experienced nightmares and paranoia in the past. The nurse noted that the man did not exhibit any psychotic symptoms but appeared depressed. The nurse completed a care plan which included the man to be reviewed by the doctor to consider antidepressants, to attend day care and to continue seeing a member of CARATs. (Although it does not appear that the man had had any engagement with CARATs since an appointment at Brixton on 8 December.)
49. On 30 January, the man told Dr A at Pentonville that he was feeling low and tearful and was suffering from poor sleep and appetite. He said he had no thoughts of harming himself and had no psychotic symptoms, although he explained he had previously been diagnosed with schizophrenia. The doctor noted that the man was keen to obtain codeine-based painkillers for the pain in his jaw. The doctor prescribed citalopram (used for the treatment of mild depression) and zopiclone to help him sleep. The doctor told the investigator:

“I must have really felt that he was really torn apart and felt very low and I thought that he would benefit from taking the medication for me to have started it but having said that, the medicine doesn’t kick in until about two weeks so he would have needed something to tie him up till then and like I said I also saw that clearly he was awaiting a review by the mental health team and they would do a thorough assessment on his mental state.”
50. On 31 January, the man was discussed at Pentonville’s mental health team referrals meeting. He had been referred by an officer as he was agitated and had said he had a history of schizophrenia. His previous assessment was discussed and although he felt low, there was no evidence of mental illness. A non-urgent referral was made for the man to be assessed by the prison psychiatrist.
51. Later that day, the man was convicted and sentenced to five months at Stratford Magistrates’ Court for an offence on 19 September 2011. On his return to Pentonville he was seen by a nurse in reception who noted no concerns.
52. On 1 February, the man did not attend an appointment with the prison doctor. No reason was recorded. On 7 February, he appeared at Snaresbrook Crown Court, for the ongoing trial.
53. On 13 February, the man did not attend an appointment with a psychiatrist, following his referral on 31 January. The appointment was rescheduled for the next week. The psychiatrist told the investigator that he assumed the man had either a social or legal visit that day. The investigator could find no evidence to suggest that the man received such a visit that day or any other reason for him

missing the appointment. Nothing was noted in his record. A new appointment was rescheduled for a week later.

54. The man failed to attend the next appointment with the psychiatrist on 20 February. The appointment was rescheduled for the following week. Again, the psychiatrist told the investigator that he assumed the man had a visit. The investigator could find no evidence that the man received a visit that day or any other recorded reason to explain the missed appointment.
55. After missing his two previous appointments the man was finally assessed by Psychiatrist A, on 27 February. The man discussed the details of his offence and the stresses at the time, including being the victim of a mugging and his mother's illness. He explained that every day he regretted hitting his friend and had no further intention to "do her wrong again". The man said that he was drinking at the time of his offence, and he did not experience any psychotic symptoms. He told the psychiatrist, as he had told previous health professionals that he had been diagnosed with schizophrenia and was admitted to the Royal Free Hospital after experiencing symptoms of psychosis. He said that he had been prescribed olanzapine by his GP since that admission.
56. The psychiatrist noted that the man had not experienced any symptoms of psychosis since his olanzapine prescription had been stopped by Dr C at Brixton. He noted that the man's mental state was stable and he denied any thoughts of harming himself or ending his life. The psychiatrist said that the man had no delusions, denied any experiences of hallucinations and was feeling well without the olanzapine. The psychiatrist concluded that the man did not need to be seen by the mental health team, unless there were any concerns about his mental health in the future. The psychiatrist recorded that they had still not received copies of reports from the man's admission to the Royal Free Hospital, despite being requested by Dr C at Brixton several months before.
57. On 4 March, six weeks after his arrival at Pentonville, Officer A introduced herself to the man as his personal officer. The officer noted in his case history notes that she explained what was expected of him on the wing and told him that she could assist him with any problems or concerns. The officer told the investigator:

"I didn't really know him that well. He was very quiet, he kept to himself. I was only his personal officer for maybe three weeks of the time that he was on the wing. I introduced myself to him as his personal officer and I asked him if he had any concerns or issues. I explained to him how the landing and the wing is run and if there's anything I can help him with he can come to me. He never did come to me for anything..."
58. Officer A said that she was appointed as the man's personal officer about three days before she wrote her entry in his case history notes. Although she had had only limited contact with the man, the officer said she saw no indication or evidence that the man was bullied or otherwise intimidated by other prisoners while he was at Pentonville.

59. On 7 March, the man was convicted at Snaresbrook Crown Court. The judge requested a psychiatric report for his sentence hearing on 20 April, as well as a pre-sentence report that addressed the issue of dangerousness as there was the possibility of an indeterminate sentence for public protection.
60. The man returned to Pentonville at 6.05pm. Senior Officer (SO) A, who works in reception, told the investigator that on return from court prisoners in the man's situation should be assessed by the senior officer on duty at the time and if there were concerns the senior officer would refer the prisoner for a healthcare assessment. There is no record of the man being assessed by a senior officer or any referral to the healthcare team.
61. During his time in Pentonville, the man spoke regularly with his mother and sister. In a call to his mother on the afternoon of 12 March, he said he had no concerns about being at Pentonville. In a telephone call to his sister later that day, he raised no concerns. In a telephone call to his mother on 23 March, he said that he had spoken to probation who said he was seen as a danger to the public so he might receive a significant prison sentence. The man also talked with his mother about her visiting him in prison and sending in money. There is no documentary record of the man's conversation with probation staff at that time, although a probation officer had booked an interview with him on 2 April to help prepare his pre-sentence report.
62. On 26 March, the man was assessed by the psychiatrist following the court's request for a psychiatric report. The psychiatrist recorded that he had no obvious symptoms of depression or psychosis and that he continued to express remorse for his offence. He noted that he did not consider that the man was at any immediate risk of harming himself.
63. The psychiatrist told the investigator that the man became a little tearful during their conversation and was worried about his sentence and his mother's health, but that he also talked of the future in a positive manner. He remained remorseful and apologetic about his offence. The man told him that... he had not felt unwell after stopping olanzapine. The psychiatrist reported that although the man said he interacted with other prisoners he was not interested in forming any friendships, preferring to be by himself. The man told the psychiatrist that he had no major issues with sleep, energy levels or concentration. The psychiatrist noted that he was not experiencing any delusional thoughts. The man told the psychiatrist that he could get up to five years in prison but said he was not feeling suicidal and had no intention to harm himself. In his report, the psychiatrist concluded that the man did not have an enduring mental illness and made no formal psychiatric recommendations.
64. At 3.20pm on 26 March, the man spoke to his mother on the telephone for about seven minutes. He explained that he might receive a prison sentence of five years, and said that he was getting 'grief' from other prisoners. (It is not clear what the man meant by that and there is no security intelligence or any evidence in wing observation books or other record that the man was the victim of bullying.) The man attempted to call his mother a further three times before 4.00pm that afternoon, but there was no answer.

65. The man's mother asked the investigator to explain what had happened to her son between her telephone conversation and his death. Unfortunately, there are no entries in the man's case history notes for the next two days, and nothing in wing observation books. None of the staff the investigator spoke to were able to say anything about the man's activities or demeanour during these two days. It has therefore not been possible to give an account of what he was doing during that time.
66. On the evening of 29 March, Officer B completed a roll check at 9.00pm, a security procedure to ensure that all prisoners are accounted for. The officer could not specifically recall checking or speaking to the man but said he noticed nothing unusual during the count. Officer B was assisted with the roll check by Operational Support Grade (OSG) A. Both said that nothing unusual happened on the wing that evening, and the OSG described it as a normal night. The man was not subject to suicide prevention monitoring, so there was no requirement for staff to check him during the night.

On the day the man died

67. At around 4.45am on the day the man died, Officer B and OSG A started the early morning roll check a little earlier than usual. The OSG started her check on the wing's top landing and the man's cell was one of the first that she checked. The OSG said that the cell was dark at the time, but she saw the man apparently sitting at the back of his cell. She knocked on the door but received no response, so she radioed for assistance. She said that she could see that the man was hanging and noticed blood on his thigh, but because of his position she could not see what he was hanging from. Within half a minute, the OSG radioed that it was a possible level one. (A level one is an emergency code at Pentonville which indicates that someone has stopped breathing and requires urgent medical assistance.)
68. Officer B was in the wing office two landings below and arrived at the cell within a minute of the alarm being raised. He was followed immediately by Officer C and Officer D. Officer B said that he looked through the cell door and could see what appeared to be the man sitting directly on the cell floor, suspended from a ripped sheet which had been tied to the bars of the window. Officer B said that he told Officer C that the man was hanging and Officer C confirmed it was a level one situation over the radio. Officer C had just been given his full set of keys by the night orderly officer to allow him to complete his final patrol before the prison opened up, so was able to use his cell key to open the man's cell and the officers went in.
69. Officer C went into the cell first followed by Officer D and Officer B. Officer C took the man's weight while Officer D cut the tied sheet from around his neck. At the same time Officer B cut the sheet from the window bars. The officers laid the man on the cell floor just as SO B, the night orderly officer and the emergency response nurse A, arrived. (The night orderly officer is the most senior member of staff on duty in the prison at night and carries keys to move around the prison,

which for security reasons other officers do not have at night.)

70. Officer C said that none of the officers checked for signs of life because the emergency response, the first nurse on the scene arrived as soon as the man had been cut down. The nurse said he was in the wing office when the alarm was called and went to the nearby nurse's treatment room to collect the emergency healthcare equipment, including a defibrillator and oxygen. The second nurse on the scene had also responded to the emergency level one alarm and they both took the emergency equipment to the man's cell.
71. When he got to the cell, the first nurse on the scene asked for confirmation that an ambulance had been called. In response SO B radioed the communications room to call an ambulance at 4.47am. The first nurse on the scene told the investigator that he and the second nurse on the scene immediately checked for signs of life, but found none. The man was cold to the touch, but nurses attempted to resuscitate him. A defibrillator was attached to the man's chest, but there was no heart rhythm and the defibrillator advised continuation of resuscitation.
72. OSG B told the investigator that he was on F wing when he responded to the level one call for assistance as all officers are instructed to do. Officer E arrived at the cell at about the same time as OSG B. When they got there, SO B gave her keys to Officer E so that they could get the prison gate key from the safe where it was kept to allow the ambulance in. SO B remained at the man's cell.
73. The key to the gate was in the prison safe and the key to the safe was in a locked key cabinet in the prison's centre office, where the wings of the prison converge. Officer E and OSG B went to the office and were joined by Officer F. OSG B said that it took up to five minutes to open the key cabinet and they considered forcing the cabinet open. At first they thought they did not have the correct key but then realised they had inserted it the wrong way round. When the officers managed to open the key cabinet, they got the key to the prison safe and then the key that opened the prison gate.
74. According to the London Ambulance Service log the ambulance was called at 4.47am, despatched at 4.49am and first arrived at the prison at 4.50am. However it was not until 5.05am that paramedics arrived at the man's cell. The control room log recorded that the ambulance arrived at the gate at 4.49am. It took about two minutes for the officers to get from the cell to the centre and a further five minutes to open the key cabinet and then they went to the gate. Because of this delay paramedics did not get to the cell until 5.05am, fifteen minutes after the ambulance first arrived at the gate.
75. The paramedics continued resuscitation attempts but pronounced the man dead at 5.15am.

Prisoner Support

76. The Governor issued a notice to all prisoners informing them that the man had died. The notice indicated the support that was available, including Listeners.

Prisoners who were subject to self-harm monitoring procedures were reviewed in case they were adversely affected by the news of the man's death.

Staff Support

77. There was a hot debrief for staff, the purpose of which is to bring together staff who have been involved in the incident, to give them a chance to talk about events and to offer support. Officers who attended told the investigator that they felt well supported by the prison's care and welfare team.

Family Liaison

78. Pentonville did not have any contact details for the man's next of kin. After his death, the prison appointed two members of staff to act as the prison's family liaison officer (FLO). After liaison with the police and the man's solicitor, prison staff eventually obtained an address for the man's sister, near Hull, at 12.00 noon. Because of the distance, an operational manager from HMP Hull, attempted to visit the man's sister at her home several times that afternoon but she was not there. Eventually the operational manager was able to tell her of her brother's death, in person, at 7.15pm.
79. The next day, 31 March, the Head of Reducing Re-offending at Pentonville, spoke to both the man's sister and mother by telephone. The man's possessions were returned during a later meeting with the family and the prison made a contribution to the man's funeral expenses.

ISSUES

80. In her clinical review, the clinical reviewer summarised the man's historic community records, including his mental health treatment at the Royal Free Hospital, which were not obtained till July 2012, four months after the man's death.
81. The man's records confirmed that he had previously been diagnosed with paranoid schizophrenia and was admitted to the Royal Free in 1997 for mental health treatment as he had reported. He was supported by community mental health services until 2003, when he was discharged because there was no evidence at the time of ongoing mental health problems. Throughout the time he was under the care of the community mental health services; mental health practitioners underlined the importance of the man's continued compliance with medication (olanzapine and zopiclone). They noted that failure to comply with his medication resulted in significantly increased risk.

Decision to stop olanzapine at Brixton

82. The man continued to be prescribed olanzapine by his GP after he was discharged from the community mental health services in 2003, so that when he arrived at Brixton he had been prescribed it for 12 years. However, at the time of his arrest in November 2012, he was on a very low dose. The doctor at Brixton stopped his prescription for olanzapine apparently because he had not taken it for a while. However, when the man arrived at Brixton it appears only to have been a matter of days since he had last taken it. After he reviewed the man's recent medical records, a consultant psychiatrist confirmed this decision as appropriate but suggested that olanzapine should be offered again if there was any relapse of psychosis. The man was assessed and supported by the mental health teams at Brixton, Wandsworth and Pentonville. The clinical reviewer raises no concerns about the treatment he received and concludes:

"The man received prompt assessments and reasonably good interventions at each prison for his physical and mental health needs."

83. Although the man complained to his solicitor about not receiving olanzapine, we are satisfied that the decision was taken by an appropriately qualified clinician after a full assessment.

Substance misuse

84. When he arrived in custody, the man told staff that he was an alcoholic. He received treatment for clinical detoxification and was seen by the CARATs team at Brixton. Despite plans for him to attend group therapy sessions at Brixton, there is no evidence of psychosocial support (to meet a person's emotional, social, mental and spiritual needs) being offered after he moved to Wandsworth. Contact with CARATs was written in the man's nursing care plan when he got to Pentonville, but there is no evidence that he received support from CARATs there either. We agree with the clinical reviewer's recommendation that:

The Governors at Wandsworth and Pentonville should ensure that prisoners are given adequate psychosocial intervention after alcohol detoxification.

Assessment after conviction

85. On 7 March, the man was convicted of grievous bodily harm and returned to Pentonville early that evening. He was possibly facing a significant sentence. There is no evidence that his risk was identified by reception staff or that he was further assessed by healthcare staff on his return from court.
86. Paragraph 4.8.1 of Prison Service Order (PSO) 2700, Suicide Prevention and Self-Harm Management, which was in operation at the time leading to the man's death required that:

“Reception/first night staff must ensure they talk with prisoners (and maintain a record of this) who have:

- a) Had a change of status (convicted, sentenced, placed on escape list and/or re categorised upwards)....”

The PSO goes on to say in section 4.8.3 that:

“Where there has been a change of status or the prisoner is a failed appellant or has been recalled, reception staff must inform the appropriate wing staff, i.e. those who will take responsibility for the prisoner.”

There is also no evidence to suggest that wing staff were informed of the man's change in circumstance on his return from court on 7 March.

87. Pentonville's own local policy, Suicide Self Harm Prevention Policy, in operation at the time of the man's death, states that:

“Prisoners who are first receptions, recalls, transfers, had a court appeal rejected or a change in immigration status or have changed status (as defined in chapter 4 of PSO 2700) including as a result of a court video link, must be assessed for suicide or self harm risk by a member of the healthcare team before the evening roll check (or for late arrivals, before they are locked-up for that night) and this is recorded in the clinical record.”

88. Prison Service Instruction (PSI) 52/2010, Early Days In Custody – Reception In, First Night In Custody and Induction to Custody, Annex D, section 4 states:

“All staff should be alert to the enhanced risk of suicide / self-harm posed by prisoners in the following categories, and act appropriately to address any concerns:

- Those whose status has recently changed (e.g. from remand to convicted / sentence, those who appeal has failed, etc.)

[...]

“Prisoners returning to the prison after a temporary absence need only be medically assessed if they are in any of the categories listed in paragraph 4 above, or if reception staff have any other concerns about their health.”

89. The instructions and local policies in place at the time of the man’s return from court on 7 March are clear. On 31 March 2012, PSO 2700 was superseded by PSI 64/2011, but the new instruction also recognises change of status as a factor that could increase an individual’s risk of self-harm. The man was not referred for an assessment by healthcare staff after he was convicted despite national and local requirements.
90. The first nurse on the scene told the investigator that it was not routine for reception healthcare staff to see prisoners who returned from court, unless there was a medical reason to do so.
91. The man was convicted of a serious offence and he was facing the possibility of an indeterminate sentence following his court appearance on 7 March. Reception staff did not refer him for a healthcare assessment and there is no record that wing staff were told about his change of status, as required by national and local instructions. No one spoke to him about the significance of the court appearance to see how he felt about it.
92. The psychiatrist conducted a psychiatric assessment of the man, on 26 March, four days before his death. The psychiatrist concluded that the man had no thoughts of harming himself. In the light of the psychiatrist’s judgement, we accept that it is unlikely that an assessment in reception when he arrived back from court would have reached a different conclusion. This assessment not long before his death suggests that it would have been difficult for prison staff to predict his actions. Nevertheless, the man’s risk of self-harm should have been assessed on his return from court when he had just been convicted and it is important that this is done for other prisoners.

The Governor and Healthcare Manager should ensure prisoners returning to the prison with a change of status are assessed by staff in reception, seen by healthcare and that wing staff are notified.

Emergency response

93. When OSG A first arrived at the man's cell she was not sure what was wrong. After she received no response from him she immediately radioed for assistance. The OSG did not call an ambulance and neither did the officers who reached the cell shortly afterwards. SO B said that it would normally be the night orderly officer who called an ambulance, although any member of staff could do so. When the first nurse on the scene arrived at the cell he asked whether an ambulance had been called. At that point SO B requested the officer in the communications room to call an ambulance. The London Ambulance Service log records that the call for assistance was made at 4.47am. As this was only two minutes after the man was found there was no unreasonable delay, but it is preferable in such circumstances that an ambulance is called immediately.
94. A document entitled 'How to Order an Ambulance' in the prison's communication room explains the procedures to be followed when calling an ambulance

"An ambulance can be requested by the Duty Doctor, Healthcare Manager, Orderly Officer or Duty Governor. Any one on the above name people may contact communications and request that an ambulance is ordered."

Staff at the prison told the investigator that anyone was able to request an ambulance, but the written guidance is at odds with this.

95. The Director of Offender Health and the Chief Executive Officer of National Offender Management Service, wrote to all prison Governors and Directors and Heads of Healthcare on 12 February, 2011. The letter highlights the importance of calling an ambulance as soon as possible in an emergency. Any delays can have a significant impact on the patient's chances of survival, so staff should not wait for the orderly officer or healthcare staff to attend. The slight delay in calling the ambulance did not have any impact in the death of the man, but in other circumstances such a delay could be crucial.
96. SO B gave OSG B and Officer E her keys to retrieve the prison gate key from the safe. In order to get the safe key the officers first had to open a small lockable key cabinet that contained the prison safe key and they spent up to five minutes trying to get the key cabinet open. Officer E said that the delay was caused because they were not familiar with the keys. While we consider that SO B acted from the best of motives in wanting to stay at the scene of the emergency incident, we consider that in these circumstances SO B should not have given her keys away. We accept that she could not have foreseen the difficulty the officers would have with opening the key safe but it would have been prudent for her to have retrieved the gate key herself, avoiding the five minute delay. This hold up in getting the gate key led directly to a delay of five minutes in the paramedics reaching the man's cell. Although it would not have changed the outcome for the man, on another occasion, such a delay could be crucial. We make the following recommendation:

The Governor should ensure that all staff understand they should request

an ambulance immediately in an emergency and that night procedures allow ambulances speedy access to prisoners in all parts of the prison.

The man's contact with staff

97. During his time at Pentonville the man was not employed and did not take part in education. As he had no allocated activity he would have spent most of his time locked in his cell with little to do. The last inspection of Pentonville in 2011 found that many unemployed prisoners were locked in their cells for up to 21 hours a day. It does not appear that the man left his cell or the wing very often. Moreover, the investigator found no one at Pentonville who knew the man well and no one could explain what he had done in the days before his death or how he had seemed.
98. From his arrival at Pentonville on 24 January, until his death, only one significant entry was made in the man's case history notes. Officer A, his personal officer, wrote this entry after she introduced herself to him on 4 March, having been appointed his personal officer a few days earlier. This was six weeks after the man's arrival at the prison.
99. Officers told the investigator that personal officer entries were expected every two weeks. In their report of June 2011, the Inspectorate noted that few personal officers made case history entries and none of the entries referred to family or resettlement issues. There was no formal personal officer policy. The investigator was told that there was still no personal officer policy at Pentonville, but that a project was under way to introduce one.
100. We are concerned that the man was not allocated a personal officer until the beginning of March 2012. We are also concerned at the apparent lack of staff interaction with him. Entries in his case history notes were poor and reflected the minimal contact that staff had with the man. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

CONCLUSION

101. The man told staff that he had a complex history of mental health involvement and the clinical reviewer considers that his mental health treatment was reasonably good. The decision to stop olanzapine seemed appropriate as the man was no longer exhibiting any signs of mental illness. The clinical reviewer was concerned that, after his clinical detoxification, the man did not receive sufficient structured support for his alcohol dependency.
102. When the man was convicted and facing a possible indeterminate sentence, he should have had a healthcare review and wing staff should have been notified. He had already expressed anxiety about his offence, but had no documented conversation with staff about how he felt after the conviction. Nevertheless, a psychiatrist assessed the man just a few days before he took his life and was satisfied that he was not at risk of suicide or self-harm.
103. We are concerned at how little prison staff at Pentonville were able to tell us about the man or how he seemed in the days before his death. It appears that no one really took the trouble to get to know him.
104. Although healthcare staff attended quickly, access for the ambulance staff was delayed by an unnecessary difficulty obtaining the keys for the prison gate. On this occasion, the outcome would not have changed because the man had been dead for some time, but there is a need to ensure swift access for emergency services.

RECOMMENDATIONS

1. The Governors at Wandsworth and Pentonville should ensure that prisoners are given adequate psychosocial intervention after alcohol detoxification.

Accepted

Pentonville Response

When a prisoner is received into custody needing alcohol detoxification they are accommodated in F wing and receive treatment through IDTS. They are then automatically referred to CARATs for psychosocial interventions.

No information was passed to Pentonville from Wandsworth regarding this need for the man and he did not put in an application for CARATs. He was therefore not known to the CARATs team.

Anyone highlighted as needing psychosocial interventions will be seen by CARATs and can also attend our Day Care centre.

Wandsworth Response

We have in place now an intervention for those with alcohol addictions, this is a programme run by Phoenix Futures and last around 4 weeks, any prisoner with alcohol issue can be referred to this.

We also have an improved flow process for prisoners coming into Wandsworth with addictions, they are seen on arrival by a member of the substance misuse team and located onto the stabilisation unit, once they are considered to be safe, they are moved to the Substance Recovery wing where they participated in IDTS group work, access to the gym and PEI led holistic groups, Staff have been trained in identifying prisoners who are in recovery and warning signs such as overdosing etc.

The Substance misuse team meet regularly with discipline and CARAT staff, communication between all parties involved in the drug recovery has improved greatly.

2. The Governor and Healthcare Manager should ensure prisoners returning to the prison with a change of status are assessed by staff in reception, seen by healthcare and that wing staff are notified.

Accepted

The following procedures have been implemented:

- *Any prisoner who has had a legal change of status is noted down by Reception;*
- *The list is collected by the Safer Custody team and logged onto a database daily;*

- *The wing staff and wing SO's are contacted with the relevant names and asked to speak to the prisoner and check his general wellbeing;*
 - *C-Nomis notes are updated accordingly;*
 - *The Safer Custody Team checks the C-Nomis notes and make note of any particular concerns. If the C-Nomis notes are then not updated the SC team email the line managers again and send out relevant reminders.*
3. The Governor should ensure that all staff understand they should request an ambulance immediately in an emergency and that night procedures allow ambulances speedy access to prisoners in all parts of the prison.

Accepted

This action will be implemented immediately.

4. The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

Accepted

*We have been running a successful Personal Officer scheme. **HIPPO** (Help and Information for Pentonville's Personal Officers) has been recognised Nationally as a great initiative and we consider this the first stage of developing the Personal Officer Scheme. Personal Officer Packs have since been published and handed out to prisoners as an additional tool to aid them and for staff to support them. It is unfortunate that more case entries were not recorded for the man, there should have been more. That is not to say that a Personal Officer did not speak with him, or interact with him. Management Checks are in place to assess quality and consistency of Personal Officer entries. **Governor's Order 04/2011**, published in March 2011, highlights the establishment's views of developing the Personal Officer scheme. Continuous improvement in this scheme is desired to improve Personal Officer contact.*