

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Terence Adams, a prisoner at HMP Pentonville, on 9 November 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Terence Adams was found hanged in his cell at HMP Pentonville on 9 November 2015. He was 43 years old. I offer my condolences to Mr Adams' family and friends.

The investigation found that Mr Adams did not receive adequate support at Pentonville. Prison staff identified that Mr Adams had a number of factors that increased his risk of suicide when he first arrived at the prison on 6 November but relied too much on his presentation and statements that he did not intend to kill himself. They therefore did not begin suicide and self-harm prevention procedures.

Mr Adams was kept separate from the general population because he was regarded as vulnerable due to the nature of his offence. I am concerned that, because there was no room in the prison's vulnerable prisoner unit, Mr Adams had an extremely restricted regime in poor conditions without even a television to help distract him. He was locked in his cell continually during his time at the prison and never had the opportunity to spend time in the open air or mix with other prisoners. There is little evidence of effective staff interaction or support.

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

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

**August 2016**

## Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6

# Summary

## Events

1. On 6 July 2009, Mr Terence Adams received an indeterminate sentence for public protection (IPP) for sexual offences with a minimum term of two and a half years to serve. He was released on licence on 2 June 2014. On Friday 6 November 2015, Mr Adams arrived at HMP Pentonville after he was recalled to prison. He had breached a condition of his licence by deleting his computer browsing history.
2. An officer and a nurse assessed Mr Adams when he arrived and both recorded that he had some risk factors for suicide and self-harm, but, based on his presentation, did not consider he was at risk. The nurse overrode the findings of an assessment tool which indicated that he should have begun Prison Service suicide or self-harm prevention procedures, known as ACCT. A doctor, who assessed him in reception, did not consider that he was at risk.
3. Mr Adams asked to be classed as a vulnerable prisoner (which meant he would be kept separately from the general population for his own protection), because of the nature of his offences. As there were no spaces in the prison's vulnerable prisoners unit, Mr Adams was given a single cell in the first night centre and remained locked in his cell over the weekend to avoid contact with other prisoners. There was no further recorded contact with prison staff that weekend.
4. On the morning of Monday 9 November, a routine early morning security check identified no concerns. An officer left a sandwich in Mr Adams' cell at 11.30am but thought there was no one there at the time. Around midday, the same officer checked prisoners in their cells and found Mr Adams hanged by a ligature made of socks. The officer cut the ligature, radioed an emergency medical code and other officers and a nurse responded. Despite signs of rigor mortis, a nurse tried to resuscitate Mr Adams. Paramedics arrived at the cell at 12.18pm and after assessing Mr Adams, recorded that he had died.

## Findings

5. We consider that the staff who assessed Mr Adams when he arrived at the prison, relied too heavily on how they thought he appeared and did not attach sufficient weight to his risk factors. We are concerned that the reception nurse did not act on a structured assessment that indicated Mr Adams was at high risk of suicide and should be referred urgently for a psychiatric assessment. No one identified that he might be at increased risk when he was given a cell in the first night centre and kept in isolation for several days until his death.
6. We are particularly concerned that Mr Adams had such a restricted regime. No one ensured that he had the statutory minimum time in the open air and he was isolated without any safeguards to check his mental health or prevent his mental health deteriorating. No member of healthcare staff checked him, as would have happened if he had been formally segregated and there was no routine staff monitoring.

7. Finally, the investigation found that staff unnecessarily tried to resuscitate Mr Adams, when it was clearly too late.

## Recommendations

- The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception, first night and induction staff, including healthcare staff:
  - Consider all the known risk factors of a newly arrived prisoner and share information when determining their risk of suicide or self-harm.
  - Review a prisoner's risk when their circumstances change.
  - Begin ACCT procedures whenever a prisoner has significant risk factors, irrespective of their stated intentions.
- The Governor should ensure that all newly arrived prisoners are appropriately supported in a suitable environment. When the vulnerable prisoners unit is full, appropriate alternative arrangements should ensure that vulnerable prisoners held elsewhere in the prison have a full regime, equivalent to other prisoners, and are checked regularly by a nominated officer to ensure their wellbeing.
- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Pentonville on 12 November 2015 and obtained copies of relevant extracts from Mr Adams' prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Adams' clinical care at the prison.
11. The investigator interviewed 12 members of staff, four jointly with the clinical reviewer, and two prisoners at Pentonville between December 2015 and February 2016.
12. We informed HM Coroner for Inner North London District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Adams' family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Solicitors acting on behalf of Mr Adams' family asked:
  - Why was Mr Adams recalled to prison?
  - Did the prison know that Mr Adams had a history of depression and had been prescribed antidepressants when he was in prison before?
  - Did prison staff consider Mr Adams was depressed?
  - Did Mr Adams tell anyone he was thinking about suicide?
  - Did Mr Adams press his cell bell before he died?
14. Mr Adams family received a copy of the draft report. The solicitor representing the family did not make any comments.
15. The initial report was shared with the Prison Service. They did identify some factual inaccuracies, which the investigator has amended at paragraphs 28, 29 and 33. The amendments did not affect our findings.

# Background Information

## HMP Pentonville

16. HMP Pentonville is a local prison that holds close to 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Pentonville was in February 2015. The inspectorate had serious concerns about poor living conditions and safety at the prison. Landing staff had little interaction with prisoners during the limited amount of time they were unlocked. The number of prisoners managed under ACCT suicide and self-harm prevention procedures was relatively low and the quality of ACCT supervision and planning required improvement.
18. Although they found that first night interviews adequately addressed safety and vulnerability concerns, inspectors had particular concerns about the regime in the first night centre. Many cells for new prisoners were filthy and covered with graffiti. Most did not have basic equipment such as pillows, televisions or kettles. Officers did not provide any additional support, reassurance or enhanced monitoring for new prisoners. A lot of prisoners spent too long in their cells and had limited access to showers and telephones to contact family and friends.
19. Inspectors found that the mental health team dealt with referrals promptly and that primary mental health services were adequate.

## Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2015, the IMB reported that most prisoners stayed in the first night centre for about a week and did not access work or education. The IMB reported that incidents of self-harm in the prison had fallen by nearly a third over the year and that the quality of ACCT documents was poor.

## Previous deaths at HMP Pentonville

21. Mr Adams was the fifth prisoner to die at Pentonville since June 2014, the third self-inflicted death. In our investigation into the death of a man in December 2014, we found that prison staff did not fully consider his risk factors for suicide and self-harm when he arrived at Pentonville. In an investigation into the death of a man in August 2015, we found that reception staff did not have a clear understanding of their responsibilities and the need to share relevant information about risk of suicide and self-harm.

## **Assessment, Care in Custody and Teamwork**

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

23. In November 2008, Mr Terence Adams was remanded to HMP Pentonville charged with sexual offences. He said he wanted to kill himself and staff managed him using Prison Service suicide prevention measures, known as ACCT, until January 2009, when they assessed he was no longer at risk. At the end of February, Mr Adams transferred to HMP Belmarsh.
24. On 6 July 2009, Mr Adams received an indeterminate sentence for public protection with a minimum period to serve of two and a half years before he could be considered for release. On 23 December, he was transferred to HMP Bure and remained there until he was released on licence on 2 June 2014. While he was at Bure, Mr Adams was prescribed antidepressants and the mental health team supported him for depression until his release.
25. On 27 October 2015, the police contacted Mr Adams' offender manager because he had deleted his computer browsing history, in breach of his licence conditions. His offender manager revoked his licence and Mr Adams was arrested on 4 November.

### Friday 6 November

26. At 2.33pm on 6 November, Mr Adams arrived at Pentonville from Harrow Police Station. The police recorded on Mr Adams' Person Escort Record (PER, a document that goes with prisoners when they move between police stations, courts and prisons) that he had been recalled to prison and he was on the sex offender register.
27. An officer reviewed Mr Adams' PER and noted that Mr Adams said he did not have any suicidal thoughts or mental health problems. Because of the nature of his offence, the officer asked Mr Adams whether he wanted the prison to consider him a vulnerable prisoner, which meant he would be kept separately from the general population for his own protection. Mr Adams agreed to this, which would normally have meant that he would have been allocated a cell in the prison's vulnerable prisoner unit.
28. An officer interviewed Mr Adams for a first night assessment and cell sharing risk assessment, which is designed to identify prisoners at risk of seriously assaulting or killing a cellmate in a locked cell. Mr Adams said that he had a history of suicide and self-harm and that the last time he was in prison it had been an issue. She noticed Mr Adams was low in mood. He told her that he had no current thoughts of suicide or self-harm. Mr Adams said that he did not know the reason he had been recalled and was anxious about it. She told him that someone would contact him to explain why he had been recalled. (There is no record that anyone contacted him to explain the reason for his recall during his short time at the prison.) She explained that he could speak to a Listener (a prisoner trained by the Samaritans to support other prisoners). Mr Adams said that he had been a Listener in a previous prison and he was aware of the help available if he needed it.
29. The officer gave Mr Adams a smokers' pack (an advance supply of tobacco) and details of his telephone account but, because of his offence, Mr Adams had to

register his contact numbers and the public protection unit had to verify each number before he could use them. (She said that this would not happen over a weekend.) She recognised that Mr Adams' recall to prison, low mood and history of self-harm were risk factors and made a note of her interview in his prison record. She told the investigator that she did not consider Mr Adams was at an immediate risk of suicide or self-harm because he seemed fine and he had been in prison before.

30. At an initial health screen, a nurse recorded that Mr Adams did not have any physical or mental health problems and that he had no thoughts of suicide or self-harm. He recorded that Mr Adams talked about his history of self-harm and mental health issues, including overdose and inhalation of carbon monoxide from a car. (He told the investigator that he did not know or ask Mr Adams when this happened.) Mr Adams said he had been prescribed mirtazapine for depression when he was last in prison.
31. The nurse assessed Mr Adams' mental health using a structured assessment, which took into account his history of self-harm and attempted suicide, mental illness and his licence recall. The assessment indicated that Mr Adams should have been admitted to the inpatient unit for urgent psychiatric assessment and was at risk of suicide or self-harm, so he should start ACCT procedures. The nurse referred Mr Adams to the GP and the mental health in-reach team for assessment, but did not record whether this was urgent. The nurse told the investigator that he did not open an ACCT because Mr Adams seemed fine at the time and said that he did not have any thoughts of suicide or self-harm.
32. A GP saw Mr Adams when he arrived and recorded that Mr Adams told him that he had a history of depression, which had been treated with counselling outside prison. He said he had been prescribed antidepressants in prison but had not taken them for a while. Mr Adams said he wanted to continue with counselling and did not want medication. The GP recorded that Mr Adams was in good mood at the time of his review, but he said that he had had suicidal thoughts for the past 20 years, which fluctuated. He recorded that Mr Adams had no plans of suicide and noted that he had been referred for a mental health assessment. The GP did not consider Mr Adams at risk of suicide or self-harm.
33. An officer thought she had allocated Mr Adams a cell sometime between 6.00pm and 9.00pm. She said that as the vulnerable prisoner unit was full and she had considered whether Mr Adams should share cell with another vulnerable prisoner in the first night centre. However, there were no other vulnerable prisoners on A Wing at the time, so Mr Adams had a single cell.
34. Pentonville does not have a policy about managing vulnerable prisoners who cannot be accommodated in the vulnerable prisoner unit. Officers told the investigator that vulnerable prisoners living on A Wing cannot mix with other prisoners, which means they have a very restricted regime. Staff told the investigator that such prisoners are unlocked to shower separately from other prisoners, but otherwise remain locked in their cells and do not spend any time in the open air.
35. Officers gave Mr Adams an induction booklet, which explained how to use the emergency cell bell to ask for help in case of a life threatening emergency or if he

wanted to speak to a Listener. Cell bell records show that Mr Adams did not use his cell bell at any time. The prisoner in the cell next to Mr Adams said he could hear cell bells in neighbouring cells and he did not ever hear Mr Adams use the cell bell.

### **Saturday 7 and Sunday 8 November**

36. At around 7.30am on 7 November, Officer A saw Mr Adams during a routine security check to establish that all prisoners were present, but did not speak to him. She told the investigator that she was aware that Mr Adams was a vulnerable prisoner and needed to be kept separate from other prisoners for his own safety. She therefore did not unlock his cell.
37. Around 12.00pm, Officer A gave Mr Adams lunch in his cell and he asked her if he could have a television. She said she could not find a spare television on the wing and believed she had told Mr Adams this when she gave him his dinner later that afternoon. She said she did not have any concerns about him. There is no evidence that anyone else spoke to Mr Adams that day.
38. On Sunday 8 November, Officer A saw Mr Adams again when she checked prisoners in the morning, at lunchtime and before dinner. Mr Adams asked for a pen and a piece of paper at lunchtime, which she gave to him that afternoon. She told the investigator that she did not recall anything concerning about his behaviour. She said that Mr Adams did not leave his cell on Saturday or Sunday. She said that when the other prisoners were not out on the wing, she believed she would have offered him the opportunity to have a shower, but she could not remember for certain whether she had. The prisoner in the cell next Mr Adams told the investigator that he had heard an officer offering Mr Adams a shower but he had said he did not want one.
39. Officer B, who also worked on A Wing over the weekend, told the investigator that she gave Mr Adams his dinner between 4.15pm and 5.30pm, although she could not remember whether this was on the Saturday or the Sunday. (As Officer A said she had given Mr Adams his dinner on Saturday, we presume this was the Sunday.) Officer B said that Mr Adams appeared fine at that time, although she did not speak to him. She said she did not notice anything unusual in his cell or anything concerning about his behaviour.
40. Mr Adams did not make any phone calls that weekend because his contact numbers had not been checked by the public protection unit. No one from the healthcare team saw Mr Adams, after he arrived on Friday.

### **Monday, 9 November**

41. At 6:45am on Monday 9 November, an officer did the morning roll check on A Wing. Although this was not recorded, he said he remembered seeing Mr Adams in bed at the time and he had no concerns about him.
42. That morning, two officers started the induction programme for new prisoners on A Wing. As he was a vulnerable prisoner and could not mix with the other prisoners on the wing, Mr Adams remained locked in his cell. There is no evidence that anyone spoke to him that morning.

43. At around 11.30am, Officer B started to give prisoners lunch in their cells on Mr Adams' landing. She opened Mr Adams' cell door and put a sandwich on a shelf for him. She said that she thought no one was in the cell at the time; she thought he had either been moved or that he was at an appointment.
44. Around 12.00pm, Officer B began to check that all prisoners were in their cells but could still not see Mr Adams. She thought the cell was empty and checked with a Supervising Officer (SO), who had overseen prisoners' movements that morning. He said that Mr Adams had not left his cell. She then went back to Mr Adams' cell and went in. She then found that Mr Adams had hanged himself with socks tied around his neck and attached to the bed frame. Mr Adams' legs were bent and his feet were behind him. There was a towel draped over the end of the bed, which meant that she had not been able to see him from the door of the cell.
45. Officer B cut the ligature from around Mr Adams' neck and at 12.01pm, radioed an emergency code blue (an emergency code blue indicating circumstances such as when a prisoner is unconscious, not breathing or is having breathing difficulties). She said that Mr Adams' body was purple and stiff. An officer in the prison's control room called an ambulance a minute later. Two officers went to Mr Adams' cell immediately and when they arrived she left the cell. An officer noted there was a deep mark around Mr Adams' neck and said his body was cold.
46. A nurse arrived. She checked for a pulse but could not find one. She noted Mr Adam's skin was grey and his body was rigid. The nurse and officer started cardiopulmonary resuscitation. The nurse told the investigator that Mr Adams' body was so stiff that it was difficult to do chest compressions. Soon after that, other nurses attended the cell with emergency equipment. They attached a defibrillator, which found no shockable heart rhythm. Staff continued to attempt chest compressions. Paramedics arrived at the cell at 12:18pm. The paramedics assessed Mr Adams and, at 12.25pm, they recorded that he had died.
47. Mr Adams left three letters to his family in his cell. He described his anxiety about being recalled. He said that he felt very isolated in prison and had nothing to do. He wrote that his mental health had been affected by his short time at Pentonville.

#### **Contact with Mr Adams' family**

48. At 4.05pm, an officer and a prison chaplain went to Mr Adams' mother's house to inform her of his death, but she was not there. A neighbour told them she would be back after 5.00pm, so they returned at 5.20pm. The officer then informed Mr Adams' mother that he had died and offered condolences and support.
49. Mr Adams' funeral was held on 11 December 2015. The prison contributed towards the costs in line with national instructions.

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

50. After Mr Adams' death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues

arising. No one identified any immediate issues. He offered his support and that of the staff care team.

51. The prison posted notices informing other prisoners of Mr Adams' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Adams' death.

### **Post-mortem report**

52. A post-mortem examination established the cause of death as suspension by ligature.

## Findings

### Assessment of Risk

53. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. When Mr Adams arrived at Pentonville on 6 November, he had been convicted of a sexual offence, had a history of attempted suicide, a history of depression and he had been recalled to prison after breaching his licence. It does not appear that he was aware of the full reasons for his recall, which would have exacerbated any anxieties he had. An officer identified and recorded his risk factors in reception, but decided that he was not at risk of suicide or self-harm, mainly because of Mr Adams' presentation and because he had said he did not intend to kill himself.
54. At an initial health assessment, a nurse used a structured tool to assess his risk of suicide and self-harm, which indicated that Mr Adams was high risk. The nurse told the investigator that Mr Adams had seemed very calm and happy, and that he engaged very well. The nurse said that he would have started ACCT monitoring if Mr Adams had expressly said that he felt suicidal and wanted to kill himself. The nurse said that he did not know the nature of Mr Adams' offence. He therefore did not know Mr Adams would be a vulnerable prisoner or that he would be kept separated from other prisoners on A Wing.
55. The officer who interviewed Mr Adams to assess him on his first night told the investigator that she did not think Mr Adams was at any immediate risk of suicide because of his open approach. She knew that Mr Adams was going to have a restricted regime on A Wing, because there was no room in the vulnerable prisoner unit, but said that she did not take this into account when assessing his risk of suicide or self-harm.
56. The investigator spoke to four officers who worked during the weekend on A Wing. None of these officers were aware of Mr Adams' recorded risk factors. Two SOs did not know Mr Adams had been recalled to prison, or that prisoners who had been recalled were at increased risk of suicide or self-harm.
57. The ACCT process relies on staff using their experience and skills, as well as local and national assessment tools to determine risk and it is not an exact science. However, we are concerned that staff relied so heavily on their perceptions of Mr Adams' appearance and what he told them, when it was evident that he had a number of risk factors which should have caused concern. It is particularly concerning that a nurse decided not to act on the results of a structured assessment that indicated that Mr Adams was at risk of suicide or self-harm, that he should start ACCT procedures and refer him for an urgent mental health assessment. We are also concerned that the staff who assessed Mr Adams initially when he arrived did not share relevant information about his risk with each other.

58. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time and should be considered as a single piece of evidence. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.
59. We are concerned that staff missed a number of opportunities during Mr Adams' reception and his brief time in the prison to collate and review his risk factors. We are also concerned that no one recognised that placing Mr Adams on a very restrictive regime on A Wing might have increased his risk and that staff did not review his risk to take this into account. In our Learning Lessons Bulletin on early days and weeks in custody published in February 2016, we identified that prison staff often missed obvious factors which increase the risk of suicide, not only in reception but also in the first days and weeks at a prison. We noted that recall made prisoners especially vulnerable and that mental health issues were often overlooked, factors that were also evident in Mr Adams' case. We make the following recommendation:

**The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception, first night and induction staff, including healthcare staff:**

- **Consider all the known risk factors of a newly arrived prisoner and share information when determining their risk of suicide or self-harm.**
- **Review a prisoner's risk when their circumstances change.**
- **Begin ACCT procedures whenever a prisoner has significant risk factors, irrespective of their stated intentions**

### **Mr Adams' location**

60. Mr Adams had a single cell in the first night centre, A Wing, and spent three nights there between Friday 6 November and Monday 9 November. As a vulnerable prisoner, Mr Adams should have been located on F Wing, the designated unit for vulnerable prisoners, but there were no spaces available that weekend. A SO told the investigator that vulnerable prisoners often have to be held in the first night centre while waiting for space in the vulnerable prisoner unit.
61. We note that in February 2015, HM Inspectorate of Prisons were concerned about the paucity of the prisoners' regime on A Wing. Inspectors pointed out that they had limited association time, which affected their well-being. They also found that prisoners had limited access to shower and contact with family and friends and that there was little to do during association, therefore most prisoners stayed in their cells. Despite the Inspectorate's criticism, little seems to have changed.
62. There was no reference in the most recent inspection report to vulnerable prisoners being held on A Wing but in previous years the Inspectorate has been very critical of this practice. In 2009 they made a specific recommendation that vulnerable prisoners should not be held on A Wing. In 2011 they found some

general improvement but were still not satisfied that there were appropriate 'overspill' arrangements for vulnerable prisoners. It is apparent that the practice at Pentonville has reverted to the previous arrangements, about which the Inspectorate was critical.

63. Mr Adams had a much more restrictive regime on A Wing than the other prisoners because he needed to be kept apart from them. It does not appear that he left his cell at any time from Friday night until he was found hanged on Monday. He could not make telephone calls, because the public protection unit had not yet approved his list of telephone contacts.
64. Mr Adams was not given the opportunity to spend any time in the open air, which the prison has a statutory duty to provide. Officers did not offer him the opportunity to go to the vulnerable prisoner unit to spend some time out of his cell, mixing with prisoners. Officers delivered meals to Mr Adams' cell, so he did not come out of his cell at mealtimes and did not leave it to have a shower. (We do not know whether he was ever offered a shower, but another prisoner believes he was.) His isolation was further compounded by the lack of even a television in his cell to help distract him. The February 2015 inspection found that first night cells were poorly prepared with many items such as televisions missing. This is a particular problem as the first few days in prison are a time of heightened anxiety for all prisoners; a poor environment and lack of support from staff can increase vulnerability.
65. We are concerned that a person such as Mr Adams, who had been recalled to prison to serve an indeterminate sentence, after a breach of his licence and with other recorded risk factors for suicide and self-harm, was effectively isolated in his cell for such lengthy period. Such restrictive conditions would not have been conducive to good mental health. It amounts to segregation without the safeguards that would operate in a segregation unit, such as a daily healthcare assessment of fitness, daily time in the open air and frequent checks by officers, healthcare staff, chaplains and managers.
66. No manager or member of healthcare staff went to check Mr Adams' welfare during his time at Pentonville or review his conditions. More frequent staff contact and interaction with Mr Adams might have helped him come to terms with his situation. None of the four staff who were on duty on A Wing that weekend could recall any specific contact with him. Only one officer said that she spoke to him, once on Saturday at lunchtime when Mr Adams asked for a television, and on Sunday when he asked for a pen and a piece of paper. In the notes he left he referred specifically to his isolation and lack of things to do.
67. Although Mr Adams had not been assessed as at risk of suicide and self-harm, we are concerned that anyone should be left in such conditions. The fact that Mr Adams had recorded risk factors and vulnerabilities exacerbated the situation. The lack of staff interaction or knowledge of his circumstances meant that no one checked his welfare and no one would have been able to identify whether there had been any deterioration in his mood. Mr Adams was effectively forgotten about during the short time that he spent at Pentonville.
68. As the Inspectorate have previously reported, holding vulnerable prisoners temporarily on A Wing does not provide an acceptable regime and increased

their vulnerability. It is particularly concerning that a prisoner with a number of risk factors for suicide, who had just been recalled to prison, could be left so isolated during his first few days in prison, a particularly vulnerable time, without appropriate support. We make the following recommendation:

**The Governor should ensure that all newly arrived prisoners are appropriately supported in a suitable environment. When the vulnerable prisoners unit is full, appropriate alternative arrangements should ensure that vulnerable prisoners held elsewhere in the prison have a full regime, equivalent to other prisoners, and are checked frequently by a nominated officer to ensure their wellbeing.**

## **Resuscitation**

69. A nurse responded to the emergency call and when she checked Mr Adams' pulse but could not find one. She noted Mr Adams was cold and his skin was grey. She also noted that his body was rigid. Although she considered that Mr Adams showed clear signs of rigor mortis, she decided to attempt resuscitation.
70. The nurse told the investigator that nurses at Pentonville will always carry out resuscitation until a doctor or an ambulance crew take over. She said that the prison does not have a guidance or protocol on resuscitation, which explains the circumstances when attempting resuscitation is futile. The clinical reviewer suggested that healthcare staff at Pentonville should review training needs about resuscitation when there are signs of rigor mortis.
71. We consider that it was not necessary to attempt to resuscitate Mr Adams. European Resuscitation Council Guidelines 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...". The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

**The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.**

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