

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Doyle a prisoner at HMP Pentonville on 28 March 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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.

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

Mr Mark Doyle was found hanged in his cell on 22 March 2017 at HMP Pentonville and died in hospital six days later. Mr Doyle was 45 years old. We offer our condolences to Mr Doyle's family and friends.

The investigation into Mr Doyle's death found deficiencies in the management of the ACCT process, specifically in assessing risk and delivering appropriate levels of observations. Control room staff did not immediately call an ambulance when the emergency was raised. Faulty cell bells were not reported and were not checked daily as required. We are troubled that mental health staff did not consider all available information in considering Mr Doyle's referral.

There have been six self-inflicted deaths at Pentonville since 2016. We are very concerned to repeat in this report recommendations that have been made in previous investigations into deaths at Pentonville.

Given these concerns, the Prisons Group Director for London and Thames Valley should commission a review on the operation and management of the ACCT process at HMP Pentonville. As part of this review, he should, in particular, assure himself that HMP Pentonville has effectively implemented all PPO recommendations following self-inflicted deaths at the prison in the last five years and provide a report to me outlining progress within 3 months of receiving this report.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

April 2018

Contents

Summary	1
The Investigation Process	4
Background Information	6
Key Events	8
Findings.....	17

Summary

Events

1. On 11 February 2017, shortly after his release from a psychiatric hospital, Mr Doyle was remanded to HMP Pentonville facing charges of criminal damage, violence, and making threats. In reception, a nurse noted that he had a history of suicide attempts, depression, and substance misuse, including heroin. The nurse also noted that Mr Doyle had recently lost his son and his father. The nurse started suicide and self-harm prevention procedures (known as ACCT) and referred Mr Doyle to the substance misuse and mental health teams.
2. A mental health nurse assessed Mr Doyle but the mental health inreach team discharged him from their caseload because he did not have a major mental disorder. Mr Doyle was supported by the substance misuse team and his risk of suicide and self-harm continued to be managed under the ACCT process. On 23 February, staff ended ACCT procedures after Mr Doyle said he was not feeling suicidal and felt 'okay'.
3. On 7 March, Mr Doyle was released from HMP Pentonville. Two days later he was arrested on charges of attempted murder, threats to kill and harassment against his partner and was returned to Pentonville. In reception, a nurse started ACCT procedures and referred Mr Doyle to the mental health and substance misuse teams. He was discharged from the mental health inreach team without a face to face assessment, but continued to be supported by the substance misuse team.
4. On 10 March, staff held an ACCT case review with Mr Doyle. Staff noted that the anniversary of the deaths of Mr Doyle's son and father could be a trigger for suicide and self-harm, but Mr Doyle would not provide the dates of their deaths.
5. On 13 March, an intelligence report noted that Mr Doyle had cut his arm but refused to see the nurse. There is no record of the incident in his medical notes, prison record or ACCT document and no case review was held.
6. Shortly before midnight on 21 March, an officer answered Mr Doyle's cell bell. He looked through the observation panel and saw Mr Doyle hanging from a ligature attached to the cell window. He called an emergency code and a few seconds later a prison manager arrived. They entered the cell and started resuscitation attempts. At 12.12am, paramedics arrived and took Mr Doyle to hospital. On 28 March, Mr Doyle's life support was turned off and at 9.10pm, staff recorded that he had died.
7. After Mr Doyle died, his sister told prison staff that 22 March was the anniversary of his son's death.

Findings

8. The investigation found that Mr Doyle had a number of risk factors for suicide and self-harm but staff relied on his presentation in setting the frequency of observations and did not schedule a case review to reassess his level of risk when he self-harmed. Case reviews were not multi-disciplinary and did not

include a member of healthcare at the first case review, a case manager was not assigned and caremap actions were not aimed at reducing risk. Staff did not consider involving Mr Doyle's family in the ACCT process.

9. We are concerned that mental health staff did not consider all relevant information when reviewing Mr Doyle's referral, including that he had recently been charged with the attempted murder of his partner.
10. The investigation also found that cell bell faults were not always reported and cell bell alarms not checked daily as required. There was a delay of five minutes in control room staff calling an ambulance after the emergency code was called over the radio. The police were not notified following Mr Doyle's death, as they should have been.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
 - Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations that reflects that risk.
 - ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk.
 - A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.
 - ACCT reviews are multidisciplinary and involve all staff who can contribute to the care of a prisoner at risk.
 - A case manager is appointed at the first case review.
 - ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for him.
 - ACCT case managers should consider involving the prisoner's family in the ACCT process when appropriate and record this in the ACCT plan.
- The Head of Healthcare should ensure that mental health referrals consider all relevant risk information to allow comprehensive and appropriately prioritised assessments.
- The Governor should ensure that staff report faulty cell bells and they are checked daily in line with PSO 5900.
- The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.
- The Governor should ensure that the police are notified following a death in custody.

- The Prisons Group Director for London and Thames Valley should commission a review on the operation and management of the ACCT process at HMP Pentonville. As part of this review, he should, in particular, assure himself that HMP Pentonville has effectively implemented all PPO recommendations following self-inflicted deaths at the prison in the last five years and provide a report to me outlining progress within 3 months of receiving this report.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator visited HMP Pentonville on 6 April 2017. She obtained copies of relevant extracts from Mr Doyle's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Doyle's clinical care at the prison.
14. The investigator and clinical reviewer interviewed 11 members of staff and one prisoner at HMP Pentonville on 17 May, 22 May and 5 July. The investigator returned to Pentonville on 13 July to interview a member of staff and conducted phone interviews with staff and prisoners on 19 July, 23 and 24 August.
15. We informed HM Coroner for St Pancras of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Doyle's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. He and the investigator met with Mr Doyle's family and their legal representation on 13 June 2017. Mr Doyle's family had a number of questions and concerns about his care in prison. They wanted to know about:
 - the qualifications of the clinical reviewer and quality assurance process for the clinical review report.
 - why Mr Doyle's methadone was stopped and how this was managed, including the medication that he was prescribed.
 - how Mr Doyle's mental health was assessed and whether he was referred for services.
 - what information about Mr Doyle's mental health history the prison had access to and considered.
 - the reasons why Mr Doyle was placed on suicide and self-harm prevention monitoring and the quality of case reviews and frequency of observations.
 - what action was taken in response to Mr Doyle's sister phoning the prison.
 - how many times Mr Doyle's cell bell was pressed the night he was found, how quickly staff answered it and what action was taken.
 - the emergency response including who arrived on the scene, the ambulance call logs and how quickly staff called paramedics and when they arrived.
 - Mr Doyle's location in prison and whether this was appropriate.
17. Mr Doyle's family received a copy of the initial report. The solicitor representing Mr Doyle wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Pentonville

19. HMP Pentonville is a local prison that holds over 1,300 young adult and adult men. The prison primarily serves the courts of north and east London. Healthcare services are provided by Care UK in partnership with Enfield and Haringey Mental Health Trust. There is a large purpose-built healthcare centre, which has 22 inpatient beds and a daycare facility for patients with mental health problems who are managed on the wings.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Pentonville was in January 2017. Inspectors reported most prisoners on suicide and self-harm prevention procedures said that they did not feel supported by or cared for by staff. The quality of ACCT documents was generally poor, with poor assessments, inconsistent case management, limited caremaps and limited recorded engagement with prisoners. Inspectors found that levels of self-harm were high and several incidents of self-harm were not recorded or reported. Inspectors were not confident that the prison did enough to address the issues raised consistently in PPO reports. Staff struggled to answer cell bells which were not always answered within five minutes.

Independent Monitoring Board

21. 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 2016, the IMB reported that staffing levels remained insufficiently low and temporary regimes had been introduced as a result. The IMB also found that adequate medical care was delivered but that the support of prisoners at risk of suicide and self-harm needed improving. They recognised that cell bells were misused by prisoners and there was often an unacceptable delay in staff answering.

Previous deaths at HMP Pentonville

22. There have been seven self-inflicted deaths at Pentonville since 2015 and this is the fourth of five self-inflicted deaths since the start of 2016. Investigations into those deaths found similar issues to those raised in this investigation, specifically in relation to relying on a prisoner's presentation rather than their risk factors for suicide and self-harm, failing to identify risk factors and procedural failures in the operation of ACCT resulting in prisoners not being provided with adequate support.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

26. On 4 January 2017, Mr Mark Doyle's partner called an ambulance because he was intoxicated on alcohol and cocaine. Mr Doyle told paramedics that he was depressed after the death of his son and father and had thoughts of suicide. Paramedics took Mr Doyle to hospital and a doctor detained him under the Mental Health Act.
27. Mr Doyle was transferred to St Ann's Hospital (a hospital with a psychiatric inpatient ward) and a psychiatrist diagnosed him with poly-substance misuse and antisocial personality disorder. (A personality disorder is a disorder in which the individual's personal characteristics cause regular and long-term problems in the way that they cope with life and interact with other people. A personality disorder is not a psychiatric illness).

February 2017

28. On 7 February, Mr Doyle was released from St Ann's hospital. Two days later, he was arrested on charges of criminal damage, using violence to secure entry to premises, and making threats.
29. On 11 February, Mr Doyle was transferred to HMP Pentonville. His Personal Escort Record (PER) noted that he had cut his arm in prison in 2009 when he was not given his medication, and that he had a history of substance misuse (a PER accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors).
30. A nurse in reception assessed Mr Doyle and noted that he had a history of self-harm and had made superficial cuts to his left arm. Mr Doyle said he did not have any current thoughts of suicide or self-harm, but the nurse started Prison Service suicide and self-harm prevention procedures (known as ACCT) and referred him for a mental health assessment. He noted in Mr Doyle's ACCT document that he was concerned about Mr Doyle because he had attempted to overdose a few days before, had lost his son recently, and had a history of depression and substance misuse.
31. A prison GP recorded that Mr Doyle had depression and cocaine dependence and had been taking methadone when he was in hospital. The GP prescribed mirtazapine (an antidepressant), methadone (a synthetic opioid used to treat heroin addiction), ibuprofen and paracetamol (pain medication), mebeverine (medication for stomach cramps), metoclopramide (medication for nausea and vomiting), omeprazole (medication for gastric reflux) and colecalciferol, folic acid and thiamine (vitamins). A nurse monitored Mr Doyle's withdrawal symptoms.
32. On 12 February, an officer conducted an ACCT assessment. Mr Doyle told the officer that he was upset about the deaths of his father and son and his mother's cancer, but that he 'felt alright' and did not want to die. The officer noted that the interview was unusual because Mr Doyle's stories were 'not adding up', but he did not explain this further.
33. Mr Doyle attended three case reviews under the ACCT process. Only one member of staff attended each review. At each review Mr Doyle told staff that he

had no thoughts of suicide or self-harm. At each review, staff assessed Mr Doyle's level of risk as low and continued to observe him every two hours until 19 February, when observations were reduced to every three hours with one conversation a day.

34. On 13 February, staff discussed Mr Doyle at the daily mental health inreach team referrals meeting, attended by an occupational therapist, two community psychiatric nurses and an assistant psychologist. The occupational therapist noted Mr Doyle's history of depression, suicide attempts and his recent admission to St Ann's hospital and that he would be reviewed by a mental health nurse later that day.
35. That evening, a mental health nurse assessed Mr Doyle who told her that he had been diagnosed with depression and had recently attempted suicide by 'binge drinking whiskey'. Mr Doyle said he felt guilty because he had fought with his son just before he died, but did not have thoughts of suicide because of his partner and daughter. The nurse noted that Mr Doyle was low in mood and would be discussed at the next triage meeting (a multidisciplinary meeting held weekly to consider referrals in more detail and attended by psychiatrists).
36. On 14 February, a psychiatrist discussed Mr Doyle's referral at the mental health inreach team triage meeting. The meeting was attended by two other psychiatrists, the mental health inreach team manager, a clinical psychologist, a mental health nurse and a member of the substance misuse team. The psychiatrist recorded that Mr Doyle would be referred to substance misuse services and a mood group, and the team would discuss his care at the next meeting after reviewing his discharge summary from St Ann's Hospital (a mood group is run by the therapy service and the primary mental health group and engages with prisoners to address low mood in groups or one to one).
37. The same day, Mr Doyle was taken to Highbury Corner Magistrates' Court and the Court Diversion Team assessed him after custody officers raised concerns about his withdrawn behaviour. A clinical forensic psychiatrist and a mental health practitioner noted in their Court Diversion Report that Mr Doyle had self-harmed in prison two days ago to relieve stress but did not have any current plans or intention to harm himself. There is no record of self-harm in Mr Doyle's prison record. They also noted that Mr Doyle did not have any symptoms of psychosis or appear depressed.
38. On 15 February, Mr Doyle told a prison GP that he wanted to reduce his methadone dose quickly. The GP explained that this would cause withdrawal symptoms, but agreed to reduce Mr Doyle's dose by 5ml the next day and noted that he would review him in five days.
39. On 17 February, an occupational therapist requested Mr Doyle's discharge summary from St Ann's Hospital. On 21 February, a psychiatrist reviewed Mr Doyle's Court Diversion Report at the weekly triage meeting, which three other psychiatrists attended. The report stated that Mr Doyle had no major mental health disorder but had traits of antisocial personality disorder. The psychiatrist noted that the mental health inreach team would discharge Mr Doyle from their caseload. The prison did not receive Mr Doyle's discharge summary from St Ann's Hospital.

40. On 23 February, an officer conducted an ACCT case review and noted that Mr Doyle said he 'was okay' and not feeling suicidal so he decided to end ACCT procedures.

March 2017

41. On 5 March, Mr Doyle told an acting Supervising Officer (SO) in a post-closure ACCT review that all of his problems had been resolved. On 7 March, Mr Doyle attended court and was released from custody.
42. On 9 March, Mr Doyle was returned to Pentonville on charges of attempted murder, harassment and threats to kill his partner. His PER noted that he had cut his arm in prison in 2009 when he was not given his medication and that he used methadone and had a history of substance misuse.
43. A nurse assessed Mr Doyle in reception. She noted that he was known to the detoxification unit, was released from prison on methadone, had attempted suicide on the day he was arrested and had a history of self-harm. She assessed Mr Doyle and recorded that he had mild withdrawal symptoms. The nurse referred Mr Doyle to the GP and to the mental health and substance misuse teams.
44. Mr Doyle told the nurse that he did not have any thoughts of suicide or self-harm, but she decided to start ACCT procedures on the basis that he had been charged with attempted murder against his partner, had a history of suicide attempts and had previously self-harmed. She also told the investigator that she was concerned about Mr Doyle's low mood.
45. A prison GP assessed Mr Doyle and noted that he had been released from Pentonville on methadone two days before but had not had any while he was in the community. The GP recorded that Mr Doyle had moderate symptoms of substance withdrawal and prescribed methadone, ibuprofen, loperamide (used to treat diarrhoea), mebeverine, metoclopramide and paracetamol.
46. An officer conducted a first night interview with Mr Doyle. Mr Doyle told him that he was 'not feeling good' about returning to Pentonville on an attempted murder charge. He said that he would try his best to get through it, but this would be hard. The officer told Mr Doyle that he could speak to a Listener whenever he felt low or just wanted to talk to someone (Listeners are prisoners trained by the Samaritans to support other prisoners). Mr Doyle was located in the substance misuse wing and a nurse monitored him throughout the night.
47. On 10 March, staff discussed Mr Doyle at the daily mental health inreach team referrals meeting, attended by an occupational therapist, two community psychiatric nurses and an assistant psychologist. The occupational therapist recorded that Mr Doyle had been reviewed on 13 February and his history showed no major mental health diagnosis but he had traits of antisocial personality disorder. The team discharged Mr Doyle from the mental health inreach team's caseload. The occupational therapist noted that Mr Doyle would be referred to the substance misuse team for support and that his risk of self-harm would continue to be managed under the ACCT process.

48. Around lunchtime, an officer conducted an ACCT assessment. Mr Doyle said that he had been thinking a lot about being rearrested on an attempted murder charge. He told the officer that the death of his father and his son had contributed to his low mood. The officer noted that Mr Doyle was withdrawn, but that he said he had not self-harmed recently, although he had tried to hang himself a month before while in St Ann's Hospital. Mr Doyle said that he was struggling to sleep and was feeling low and had been thinking about suicide. When the officer asked how he would attempt suicide, Mr Doyle said, 'no comment' but that he did not have the means to do it in prison. The officer asked Mr Doyle to explain what he meant but he would not say anything more about this. The officer noted that Mr Doyle was to be observed hourly.
49. At 2.41pm, Mr Doyle's sister phoned and spoke to an administration officer in Safer Custody. She said that she was concerned about her brother because he had recently been released from mental health care and previously attempted suicide and self-harmed. The administration officer told Mr Doyle's sister that staff knew about these concerns and he was currently being managed under suicide and self-harm prevention procedures. She noted the conversation in Mr Doyle's prison record.
50. At 3.40pm, an acting SO held Mr Doyle's first ACCT case review. No other staff attended the review, including healthcare. The acting SO noted that Mr Doyle was in a low mood and gave only yes and no answers to questions. Mr Doyle said he had no thoughts of self-harm but also said that he had no reason to live. The acting SO recorded in the caremap that Mr Doyle would work with the substance misuse team to address his drug and alcohol use. He noted the anniversary of the death of Mr Doyle's father and son as a trigger in the ACCT document, but said that Mr Doyle did not tell him when they died. The acting SO assessed Mr Doyle's risk as high and reduced his observations to every two hours. He scheduled another case review in 10 days time to allow Mr Doyle to settle in to the substance misuse wing and engage with the substance misuse team.
51. On 13 March, Mr Doyle asked a prison GP for sleeping tablets. The GP told him that he could not be prescribed this medication because he was taking methadone and booked an appointment for Mr Doyle to see the GP the next day. The GP noted that he would continue to monitor Mr Doyle's withdrawal and that Mr Doyle was interested in attending substance misuse groups.
52. The same day, an officer submitted an intelligence report noting that Mr Doyle had cut himself but had refused to be seen by a nurse. There is no note about this in Mr Doyle's medical or prison record or in his ACCT document.
53. On 14 March, Mr Doyle would not take his methadone because he said it stopped him from sleeping. A nurse explained that he should take his methadone and they would discuss reducing his dose next week. Mr Doyle agreed to keep taking his methadone and a nurse noted that Mr Doyle should be prescribed two days worth of zopiclone (sleeping medication).
54. The same day, an interventions worker in the substance misuse team assessed Mr Doyle and noted he was engaged but seemed frustrated. Mr Doyle told her he had low motivation levels and all that was on his mind was his upcoming court

date. She gave Mr Doyle some information on mixed and poly drug use, blood borne viruses, risks taking drugs, overdose awareness and tolerance levels.

55. On 15 March, Mr Doyle attended a substance misuse group session on NPS awareness. The same day, staff discussed Mr Doyle at the daily mental health inreach team referral meeting. An occupational therapist noted that there was no evidence that Mr Doyle had a severe or enduring mental illness, and that he was currently being managed under the ACCT process. She discharged Mr Doyle from the mental health inreach team's caseload and recorded that he would continue to be managed under the ACCT process.
56. On 16 March, Mr Doyle told a prison GP that he wanted to stop taking methadone. The GP noted that Mr Doyle would be prescribed medication to treat the symptoms of withdrawal (Ibuprofen, loperamide, mebeverine, metoclopramide, paracetamol) and zopiclone (sleeping medication).
57. A nurse assessed Mr Doyle and noted that he appeared to be in a low mood. Mr Doyle said that he had back pain and had previously taken pregabalin which helped (pregabalin is medication used to treat nerve pain, epilepsy and anxiety). He told the nurse that he was worried about his offence but said he did not have any thoughts of suicide or self-harm. The nurse referred Mr Doyle to the GP and to the mental health inreach team so he could be supported in a low mood group. A prison GP recorded that Mr Doyle was not able to start pregabalin and that he had never said anything about having back problems before.
58. On 17 March, an occupational therapist reviewed Mr Doyle's referral at the daily mental health inreach team meeting. She recorded that Mr Doyle did not have a severe and enduring mental illness. She also noted that Mr Doyle was low in mood but that he had been seen by the GP the day before and was triaged by the mental health inreach team in February and sent a follow-up letter about the outcome. She closed the referral to the mental health inreach team and noted that Mr Doyle would continue working with the substance misuse team.

19 March

59. At approximately 2.00am on 19 March, an officer noted that Mr Doyle kept pressing his cell bell asking for pain medication. She said that when Mr Doyle pressed his cell bell, she was managing a fire and a flood in the cell opposite and could not answer Mr Doyle. The officer said that Mr Doyle could see what was happening, but kept pressing his cell bell. It is not clear from Mr Doyle's records whether Mr Doyle was given pain medication that night.
60. At 3.49pm, Mr Doyle asked a mental health nurse if he could start methadone again because he could not sleep. The nurse noted that Mr Doyle appeared uncertain, preoccupied and spoke quietly. He explained to Mr Doyle that it might take another two days before his withdrawal symptoms would ease off and he would be reviewed on 22 March.
61. At 7.00pm, Mr Doyle collected his medication. At 8.35pm, Mr Doyle pressed his cell bell and asked for pain medication. An officer noted that the nurse had given him medication but he was asking for something stronger. At 10.32pm, Mr Doyle

told the officer that he was suffering because he had stopped taking methadone but the medication was not working for him.

62. At 11.20pm, a nurse recorded that Mr Doyle kept pressing his cell bell asking for codeine (pain medication). She told Mr Doyle that she could only give him paracetamol but he said that he only wanted codeine and that he wanted to go back on methadone. Mr Doyle also asked for tobacco. The nurse told him that he could not have codeine and that he would see the doctor the following day. An officer gave Mr Doyle some tobacco, and at 12.27am, an officer noted that he was awake but settling down. Mr Doyle did not see a doctor the next day but had a review scheduled for 22 March.

20 March

63. At 6.25am on 20 March, Mr Doyle asked an officer for pain medication. It is not clear from his records whether Mr Doyle was given any medication.
64. At 2.10pm, Mr Doyle moved from the substance misuse wing to G wing. That afternoon, Mr Doyle attended an ACCT case review with a SO. No other prison staff attended the review. Mr Doyle said that he had not self-harmed for a while but had not slept for about two days. He told the SO that the sleeping tablets were not working and he needed to start taking methadone again. She recorded that he would continue to be managed under the ACCT process and noted his sleeping problems in his caremap with an action for him to see his doctor about medication. The SO assessed his risk as unchanged (high) and recorded that staff should observe him every two hours with one conversation per day. She told investigators that she did not change Mr Doyle's level of risk or observations because she did not know him and there had been no change from the previous review.
65. At 11.00pm that evening, Mr Doyle asked an operational support grade (OSG) if he could speak to a Listener. She noted that he would need to wait for his turn. At 11.20pm, Mr Doyle asked staff for tobacco. At 1.15am, Mr Doyle told the OSG that he could not sleep and asked her to turn off his light.
66. At 2.45am, a prison manager took Mr Doyle to see a Listener. The OSG said that when Mr Doyle was out of his cell speaking to a Listener, his cell bell was activated. She said that when she went to the cell, Mr Doyle's cellmate was asleep so she told an officer that she thought there was something wrong with the cell bell. There is no record that prison staff reported a fault with Mr Doyle's cell bell that night.
67. A Listener spoke to Mr Doyle that night but told the investigator that he could not remember the conversation. He said that if a prisoner told him that they had thoughts of suicide or self-harm, he would only tell prison staff if the prisoner had given their consent. If he was concerned about a prisoner, he would tell a Samaritan and they would follow-up with the prisoner. The prison manager said that nobody spoke to him about any concerns they had for Mr Doyle that night. Mr Doyle went back to his cell at 3.15am and it was noted in his ACCT document that he was lying in bed and appeared asleep at 4.30am.

Events of 21 March

68. At 10.30am on 21 March, Mr Doyle went to collect his medication and told an officer that he felt like 'shit'. The officer told Mr Doyle to try to relax.
69. At 11.15am, an interventions worker spoke to Mr Doyle about whether he wanted to continue attending substance misuse groups because he had spent his last session talking to another prisoner. She said that Mr Doyle spoke quietly and seemed calm. He told her that he was very worried about his court case and was feeling a bit low. She suggested that Mr Doyle should make an appointment with the GP. Mr Doyle said he wanted to attend other substance misuse groups so she suggested possible options.
70. That afternoon, a prisoner said that Mr Doyle had locked himself in his cell and did not seem himself. He said that Mr Doyle did not say what was wrong but he did not want to speak to anyone. Mr Doyle's cellmate said that Mr Doyle seemed agitated that afternoon.
71. At around 5.00pm, staff locked Mr Doyle and his cellmate in their cell. His cellmate said that he did not really speak to Mr Doyle that evening. His cellmate said that Mr Doyle turned the light off sometime between 9.15 and 9.30pm. At around 9.30pm, his cellmate fell asleep.
72. From approximately 7.53pm until 9.50pm, Mr Doyle's cell bell was activated 18 times. The call reset button was pushed by a member of staff within five minutes each time, and usually within one or two minutes (the call reset button is outside the prisoner's cell and must be pushed by a member of staff to reset the cell bell).
73. At approximately 8.45pm, the officer on night duty on Mr Doyle's wing started his shift. He said that Mr Doyle pressed his cell bell several times saying that he was in pain because he had stopped taking methadone.
74. At around 9.30pm, Mr Doyle asked the officer for pain medication. He said that Mr Doyle was calm when he spoke, and he told him that he would speak to the nurse. The officer called a nurse, who checked Mr Doyle's medical record and noted that he could be given paracetamol and ibuprofen. At around 10.00pm, she went to Mr Doyle's cell and gave him his medication. She said that Mr Doyle did not seem distressed and appeared stable in his withdrawal.
75. At 11.00pm, the OSG checked on Mr Doyle as part of the ACCT process. Mr Doyle was awake and sitting on his bed and seemed calm. Mr Doyle asked for medication to help him sleep. The OSG thought he had asked for co-codamol (a mixture of paracetamol and codeine). She explained to Mr Doyle that he had already been given his medication, but told an officer that Mr Doyle had asked for medication again. The officer said that he would go and speak to Mr Doyle.
76. From 11.00pm until approximately 11.30pm, Mr Doyle's cell bell was activated 11 times. The cell bell records indicate that a member of staff went to reset the cell bell within a few minutes each time. Neither the officer nor the OSG, who were the only members of staff working on the wing, could remember answering these cell bells.

77. Cell bell records show that Mr Doyle's cell bell was activated at 11.41pm. Prison staff told the investigator that the times recorded for the cell bell alarm were not accurate, but suggested the recorded time may be 15 minutes early. The officer told the investigator that he thought the cell bell was activated shortly before midnight. When the officer arrived at Mr Doyle's cell and looked through the observation panel, he saw Mr Doyle hanging from a ligature made with bed sheets and attached to the window. At 11.49pm, he called an emergency code blue (an emergency code indicating that the prisoner is not breathing). A few seconds later, the prison manager arrived and unlocked Mr Doyle's cell. The prison manager and the officer went into Mr Doyle's cell, and his cellmate woke up as they came into the cell. The officer used his fish knife to cut the ligature from where it was attached to the window, and then cut the ligature from Mr Doyle's neck. He noted that Mr Doyle was not breathing.
78. Approximately three minutes later, a nurse arrived at Mr Doyle's cell with the emergency bag and defibrillator machine (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). She observed that Mr Doyle was not breathing and the officer and prison manager moved Mr Doyle onto the landing so they could start cardiopulmonary resuscitation (CPR). At 11.54pm, control room staff called an ambulance. The prison manager started chest compressions and took turns doing CPR with the nurse, the officer and two other officers who had arrived at Mr Doyle's cell.
79. At 12.02am, another nurse arrived at Mr Doyle's cell. She said that Mr Doyle was not breathing, was cold to touch and his colour was pale. One nurse managed Mr Doyle's airways and gave him oxygen. The other nurse attached the pads from the defibrillator machine but it advised no shockable rhythm. One of the nurses noted that Mr Doyle had a deep ligature mark around his neck and he was bleeding from his nose. Staff continued CPR and one of the nurses noted that Mr Doyle's eyes were enlarged and fixed.
80. At 12.12am, paramedics arrived and took over the Mr Doyle's care. Paramedics gave Mr Doyle oxygen, continued CPR and gave him drugs for his heart. They noted that Mr Doyle was breathing and took a blood pressure reading. At 12.52am, they transferred Mr Doyle to University College London Hospital.
81. An officer took Mr Doyle's cellmate to the shower room on another landing. The prison manager and an officer asked Mr Doyle's cellmate what had happened. He said that he was asleep and only woke up when the prison manager and officer came into the cell. He said that he didn't know what had happened and did not know Mr Doyle very well. The prison manager said that after speaking to Mr Doyle's cellmate they concluded that he had not been involved in the incident and decided not to call the police.
82. At 4.18am on 22 March, one of the nurses made an entry in Mr Doyle's medical records about the emergency response. At approximately 8.00am, she made a second entry in Mr Doyle's medical records saying that he had requested paracetamol and ibuprofen the night before and 'appeared to be distressed at the time.' At 9.51am, she made a further entry in Mr Doyle's medical record noting that there was an error in her previous entry. She recorded that Mr Doyle did not appear to be distressed when she gave him painkillers the night before and that

he was not agitated or distressed in any way. She told the investigator that she was tired when she wrote the first entry and made a mistake when she was typing. She said that she meant to write that Mr Doyle was 'not distressed' but left out the 'not'. She said that she would not normally make an entry in a prisoner's medical record when she gave them painkillers, but decided to do so after Mr Doyle was taken to hospital because she thought the information might be useful.

83. At 11.35am, an officer went to speak to Mr Doyle's cellmate. He said that what happened last night had 'hit him more' and the officer arranged for a chaplain to visit him to provide support.
84. At 8.00pm on 28 March, Mr Doyle was taken off life support and at 9.10pm, hospital staff recorded that he had died.
85. After Mr Doyle died, his sister told prison staff that 22 March was the anniversary of his son's death.

Contact with Mr Doyle's family

86. On 22 March 2017, a prison family liaison officer asked the police to contact Mr Doyle's brother because he was unable to contact him on the number Mr Doyle had given. At 4.05pm, Mr Doyle's brother contacted the prison and spoke to the family liaison officer. Mr Doyle's brother said that his sister would be contacting the prison to find out what happened. At 4.30pm, Mr Doyle's sister spoke to the family liaison officer and he arranged to meet her at the hospital the next day. The prison contributed to the costs of Mr Doyle's funeral, in line with national guidance.

Support for prisoners and staff

87. After Mr Doyle's death, the prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues, and to offer support. The staff care team also offered support.
88. The prison posted notices informing other prisoners of Mr Doyle's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Doyle's death.

Post-mortem report

The post-mortem report noted Mr Doyle's cause of death as post-cardiac arrest hypoxic-ischaemic brain injury due to ligature compression of the neck. The toxicology report noted that the only drugs found in Mr Doyle's system were given to him as part of his treatment in hospital.

Findings

Management of the ACCT process

89. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include a history of suicide attempts and self-harm, a personality disorder diagnosis, a recent discharge from a psychiatric inpatient facility, a charge of a violent offence against a partner, detoxification from substances and a bereavement anniversary. All these factors applied to Mr Doyle.
90. Staff correctly began ACCT suicide and self-harm prevention procedures as soon as Mr Doyle arrived at Pentonville and he was monitored under ACCT procedures throughout his time there. However, we have concerns about the management of his risk and the ACCT process.

Level of risk and observations

91. At Mr Doyle's first case review in March, he had a number of risk factors and triggers and said that he was low in mood and had no reason to live. The acting SO assessed Mr Doyle's risk of suicide and self-harm as high but reduced his observations from hourly to once every two hours. The acting SO said that he assessed Mr Doyle's risk as high because he said he had no reason to live, but decided to decrease the frequency of his observations because he did not note any major concerns in his ACCT document and he thought he would give Mr Doyle a little more privacy.
92. At interview, the acting SO said that he was not 'majorly concerned' about Mr Doyle at the time, but on reflection, he would have included some conversations in addition to observations every two hours so that Mr Doyle had some engagement with staff. We are concerned that the frequency of observations set by the acting SO did not appropriately reflect Mr Doyle's assessed level of risk.
93. On 19 and 20 March, Mr Doyle said that he was in pain from his methadone withdrawal and asked for medication. PSI 64/2011 states that substance withdrawal is a trigger that could increase a person's risk of suicide and self-harm, yet this was not noted in Mr Doyle's ACCT document. Staff recorded that Mr Doyle would work with the substance misuse team as an action in his caremap to address his drug and alcohol use, but staff failed to consider the effects of withdrawing from substances on his level of risk of suicide and self-harm.

Response to self-harm

94. PSI 64/2011 states that an ACCT case review must be held where there is an increase in frequency or lethality of self-harm so that staff can consider if another assessment is required. On 14 February, Mr Doyle's Court Diversion Report noted that he had self-harmed in prison two days before but there is no mention of this in his prison or medical records. Staff should have investigated whether Mr Doyle had self-harmed on 12 February and arranged an ACCT case review to reassess his level of risk.

95. On 13 March, an intelligence report noted that Mr Doyle had cut his arm but did not want to see a nurse. This incident was not documented in Mr Doyle's ACCT document, medical records or prison record and there is no evidence that the person who made the intelligence report spoke to wing staff about the incident. Following this episode of self-harm, staff should have held a case review to reassess Mr Doyle's level of risk and observations.

Multidisciplinary case reviews and continuity of care

96. PSI 64/2011 requires that healthcare attend the first case review and that a case manager must be appointed at this time. It also states that ACCT case reviews must be multidisciplinary where possible because this is the most effective way to assess and manage risk, and that the ACCT process will operate more effectively if there is continuity in the attendance of staff.
97. Healthcare did not attend the first case review and a case manager was not appointed either time that Mr Doyle was managed under the ACCT process at Pentonville. For his first case review on 10 March, the acting SO said that he was not aware that healthcare must attend the first case review until he was told this at his recent ACCT training. Only one member of staff attended each case review with Mr Doyle and each review was held by a different staff member so there was no continuity in his care.

Caremap

98. PSI 64/2011 states that caremap actions should be detailed and time-bound, and aimed at reducing the risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress. Mr Doyle had been arrested on an attempted murder charge against his partner and said he had been coping with the deaths of his son and father. He had also attempted suicide during a recent stay in a psychiatric hospital, had ongoing thoughts of suicide, was withdrawn and had mental health problems. Staff did not adequately reflect these issues in the caremap which only identified Mr Doyle's drug and alcohol use and sleeping problems as issues. Engaging with the substance misuse team was listed as an action to address his drug and alcohol use, but this was noted as being 'ongoing' which is not time-bound.

Family contact

99. PSI 64/2011 says that prisoners who pose a risk of harm to themselves must be encouraged to communicate with their families, and that consideration must be given to inviting the prisoner's family to ACCT case reviews where this is thought to be beneficial. Prisoners' families, the people who know them best, can provide vital insight and information about their risk of suicide.
100. Despite Mr Doyle's sister contacting the prison with concerns, there is no evidence that staff considered inviting Mr Doyle's family to case reviews or otherwise involving them in the process. Mr Doyle was found hanged in his cell on the eve of the anniversary of his son's death. Although staff noted that the anniversary of Mr Doyle's son's and father's deaths could be a trigger for suicide and self-harm, they made no attempt to establish the date of their deaths when Mr Doyle would not tell them. Mr Doyle's family could have provided this

information to staff which would have assisted them in managing and mitigating Mr Doyle's risk of suicide and self-harm. We make the following recommendation:

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

- **Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations that reflects that risk.**
- **ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk.**
- **A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.**
- **ACCT reviews are multidisciplinary and involve all staff who can contribute to the care of a prisoner at risk.**
- **A case manager is appointed at the first case review.**
- **ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for him.**
- **ACCT case managers should consider involving the prisoner's family in the ACCT process when appropriate and record this in the ACCT plan.**

The Prisons Group Director for London and Thames Valley should commission a review on the operation and management of the ACCT process at HMP Pentonville. As part of this review, he should, in particular, assure himself that HMP Pentonville has effectively implemented all PPO recommendations following self-inflicted deaths at the prison in the last five years and provide a report to the Ombudsman outlining progress within 3 months of receiving this report.

Mental health and substance misuse care

101. The clinical reviewer found that Mr Doyle's substance misuse care was equivalent to that which he could have expected to receive in the community. Although Mr Doyle asked to start taking methadone again after deciding he wanted to stop taking it on 16 March, he was monitored by healthcare and was to be reviewed by the GP on 22 March once his withdrawal symptoms had stabilised.
102. When Mr Doyle was returned to Pentonville in March 2017, he was referred to the mental health inreach team. The clinical reviewer found that in considering Mr Doyle's referral, the mental health inreach team relied too much on his previous triage in February and did not consider all available evidence in assessing his risk. The mental health inreach team did not obtain Mr Doyle's discharge summary from St Ann's hospital or his community mental health records. They also failed to consider the impact on Mr Doyle of having been charged with the attempted murder of his partner, whom he had previously said was a protective factor against his risk of suicide and self-harm.

103. Mr Doyle's referral in March was not considered by the mental health inreach team weekly triage meeting and therefore a psychiatrist did not have input. After a mental health nurse referred Mr Doyle to the mental health inreach team for a second time on 16 March, the mental health inreach team referrals meeting considered that Mr Doyle had been seen by a GP the day before. However, the focus of this appointment was on his request for pain medication and the GP did not assess or consider Mr Doyle's mental health.
104. The clinical reviewer concluded that the care provided by the mental health inreach team was not acceptable and that their consideration of Mr Doyle's referral 'lacked background information and was overly reliant on the previous triage without considering the quality of that review.' The clinical reviewer found that the mental health inreach team's consideration of Mr Doyle's referral was not comparable to what he would have received in the community. We make the following recommendation:

The Head of Healthcare should ensure that mental health referrals consider all relevant risk information to allow comprehensive and appropriately prioritised assessments.

Cell bells

105. The prison manager said that he had reported a fault with the cell bell in Mr Doyle's cell before he and his cellmate were located there. Staff told him that when they answered the cell bell, the prisoners occupying the cell at the time said they had not pressed it and 'it just kept going off.'
106. On 20 March, the OSG said Mr Doyle's cell bell was activated when Mr Doyle was away from the cell speaking to a Listener and his cellmate was asleep. She told an officer that she thought there was something wrong with the cell bell, but there is no evidence any action was taken. The officer also said that when he answered Mr Doyle's cell bell on 20 March, the lights were off and both prisoners were asleep. After Mr Doyle was found in his cell, the officer reported the cell bell was faulty because he did not think that Mr Doyle or his cellmate could have activated it that night. The prison manager said that he was not aware of any problem with Mr Doyle's cell bell at the time Mr Doyle was in the cell. We are concerned that even though staff thought that Mr Doyle's cell bell may have been faulty, this was not reported.
107. PSI 28/2011 'Accommodation Fabric Checks' states that cell call alarm bells must be checked daily in accordance with PSO 5900 (Prison Service Technical Order). If these are checked currently as part of the daily fabric checks, then other arrangements will need to be made to ensure the cell bells are checked daily. Any major faults of fabric damage should be reported immediately to the Residential Manager and Security Department.
108. The officer said that accommodation fabric checks are carried out every second day at Pentonville. He said that cell bell checks are carried out as part of these checks. While we acknowledge that in these circumstances the faulty cell bell resulted in Mr Doyle receiving earlier medical attention, in other situations an unchecked faulty cell bell could compromise prisoner safety. We are concerned that cell bells are not checked daily in line with PSI 28/2011 and that staff did not

report that Mr Doyle's cell bell may have been faulty on 20 March. We make the following recommendation:

The Governor should ensure that staff report faulty cell bells and they are checked daily in line with PSO 5900.

Emergency response

109. PSI 03/2013 on Medical Emergency Response Codes requires staff to use a code blue or equivalent code in a medical emergency and for the control room to call an ambulance immediately after an emergency code is used. The PSI is clear that prisons should not wait for healthcare staff or a duty manager to decide whether an ambulance is needed and that an ambulance can be cancelled later if not needed.

110. Although the officer called an emergency code shortly after finding Mr Doyle and healthcare staff arrived within minutes, there was a delay of five minutes between staff calling the emergency code and the control room calling an ambulance. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

Notifying the police

111. PSO 1400 'Incident management' requires that police be notified following a death in custody. PSI 64/2011 states that all deaths in custody are treated as suspicious by police, which is particularly important where the death has occurred in a shared cell. After Mr Doyle's death on 28 March, the prison did not notify the police. We make the following recommendation:

The Governor should ensure that the police are notified following a death in custody.

**Prisons &
Probation**

Ombudsman
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