

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tyrone Givans a prisoner at HMP Pentonville on 26 February 2018

A report by the Prisons and Probation Ombudsman

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 I oversee can improve their work in the future.

Mr Tyrone Givans died on 26 February 2018, after being found hanged in his cell at HMP Pentonville. He was 32 years old. I offer my condolences to Mr Givans' family and friends.

This is a troubling investigation. Mr Givans was at Pentonville for less than three weeks. He had several factors which increased his risk to himself when he first arrived there. I am concerned that staff did not sufficiently consider these risk factors. As I often find, there was an over-reliance on Mr Givans' presentation and assurances that he had no thoughts of suicide or self-harm.

I am very concerned that although Mr Givans was profoundly deaf, staff did not make any meaningful efforts to obtain his hearing aids. Nor did they consider how his disability increased his vulnerability or whether any reasonable adjustments were needed. It is extremely disappointing that Mr Givans was not referred to the dedicated equalities officer at Pentonville, who could have put measures in place to support him and reduce his likely sense of isolation and insecurity.

I am also concerned that, although there were suggestions that Mr Givans felt under threat, this was not documented and no action was taken to address his concerns.

We cannot rule out the possibility that psychoactive substances (PS) played some part in Mr Givans' death. We were told by other prisoners that Mr Givans used PS on a regular basis at Pentonville, and he was known to have a significant substance misuse problem in the community. It is, therefore, troubling that wing staff told us that they were not aware that Mr Givans' was using drugs and had no concerns that this might be an issue. It is particularly noteworthy that Mr Givans killed himself while living on the prison's detoxification wing.

It is hard not to conclude that the absence of meaningful contact with Mr Givans by prison staff meant that opportunities to identify and understand the issues which led to him killing himself may very well have been missed. On that basis, I consider that the Governor should review the operation and management of F wing which clearly failed to provide Mr Givans with the support he needed.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

December 2018

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Summary

Events

1. On 7 February 2018, Mr Givans was remanded into custody charged with breaching a restraining order and possession of a knife at his ex-partner's flat. He was profoundly deaf and did not have his hearing aids with him. A court custody officer completed a suicide and self-harm warning form, detailing Mr Givans history of self-harm and current low mood. The Person Escort Record which accompanied Mr Givans noted that he had said he would self-harm if taken to prison.
2. On arrival at Pentonville, an officer and a nurse assessed Mr Givans. He had a history of drug and alcohol misuse in the community. He told both members of staff that he had no thoughts of suicide or self-harm. Neither considered him to be a risk to himself. Mr Givans told the nurse that he was anxious. Although the nurse and the officer intended to refer him to the mental health team there is no evidence that they did this. They also noted that Mr Givans was deaf and did not have his hearing aids but made no effort to obtain these or to refer him to the prison's equalities officer. Mr Givans was located on F Wing which functions as a detoxification wing.
3. A GP assessed Mr Givans and prescribed him medication to try to minimise his withdrawal symptoms from alcohol. On 8 February, another GP assessed Mr Givans and prescribed him antidepressants.
4. Prisoners who knew Mr Givans told the investigator that he used psychoactive substances (PS) for at least some of the time he was at Pentonville. His cellmate thought that he became increasingly paranoid during his time at the prison. None of the staff the investigator spoke to suspected that Mr Givans was using drugs.
5. On 16 February, a nurse assessed Mr Givans. She concluded that he did not meet the threshold for a referral to the mental health team and she had no concerns that he was a risk to himself.
6. On 19 February, Mr Givans was visited by his aunt. Mr Givans told her that he did not like being located on his current wing, did not have his hearing aids and felt vulnerable as a result. His aunt reassured him and told him that his mother would be visiting in two days. She said that she asked officers to look after Mr Givans as he was vulnerable.
7. On 21 February, Mr Givans' mother visited and gave Mr Givans one of his hearing aids. He told his mother that he wanted to move wings as he did not feel safe and his mattress had been slashed when he was out of his cell. His mother reported this to a member of staff who went to see Mr Givans. They went to speak to a wing supervising officer (SO) together. The SO said Mr Givans did not tell her that he felt unsafe or that he wanted to move wings, only cells. Mr Givans did not move cells before he died.
8. On 26 February, Mr Givans' cellmate went to court and Mr Givans spent the day alone in the cell. He rang his cell bell seven times, the last time at 5.09pm, but gave staff no cause for concern when they answered and spoke to him. An

officer also spoke to him during a roll check at around 5.00pm and said he seemed fine.

9. At around 6.00pm, Mr Givans' cellmate returned from court and was taken back to the cell by an officer. They found Mr Givans had hanged himself in his cell. Staff cut Mr Givans down, summoned emergency assistance and started chest compressions. Paramedics arrived and continued treatment but pronounced Mr Givans dead at 7.24pm.

Findings

Identifying risk of suicide and self-harm

10. Mr Givans had some risk factors for suicide and self-harm when he arrived at Pentonville. We consider that reception staff at Pentonville should have been more alert to them. While this need not automatically have led to them starting suicide and self-harm prevention procedures (known as ACCT), it should at least have been explicitly considered.

Mr Givans' disability

11. Mr Givans was profoundly deaf. Several staff noted this on his record but do not appear to have been proactive in obtaining his hearing aids. No reasonable adjustments were made, no one considered whether Mr Givans was more vulnerable in prison as a result and no one referred him to the equalities officer who had expertise in working with deaf prisoners.

Drug use

12. Mr Givans lived on F Wing, the detoxification wing. Two other prisoners we spoke to said that Mr Givans used psychoactive substances (PS) at Pentonville. It has not been possible to verify this, but it is of concern that, staff were oblivious to this potential drug use, not least given Mr Givans' significant history of drug problems in the community.
13. Although post-mortem toxicology tests did not detect PS, the tests only covered a small number of PS variants. We do not consider that we can rule out the possibility that PS may have played some part in Mr Givans' death.

Mr Givans' location at Pentonville

14. Mr Givans told his mother that he felt unsafe in his cell and wanted to move wings. She said she told staff this information and was assured that this would happen. An officer said that she went with Mr Givans to speak to a SO about his wish to move wings because he did not feel safe. The SO gave us a different account of what was said. No record was made of Mr Givans' concerns.
15. Although a personal officer scheme was apparently established at Pentonville following a previous death at the prison in 2016, there was no personal officer scheme in place at the time of Mr Givans' death. We note that Pentonville will start implementing a new offender management model as part of a national roll-out in January 2019 but consider the issues identified in the course of this investigation require more urgent attention.

Clinical care

16. The clinical reviewer concluded that Mr Givans' care was not equivalent to that which he could have expected to receive in the community. The reception nurse did not attempt to obtain his community records and did not conduct a drugs test although Mr Givans said he had been using crack cocaine daily. Mr Givans had two separate sets of prison medical records. This should have been identified but this did not happen until after his death. Mr Givans was not reviewed and observed in line with the local policy for alcohol detoxification, nor was he referred to the mental health team as intended. Having prescribed Mr Givans antidepressants, the GP made no appointment to review him.

Recommendations

- The Governor and Head of Healthcare should ensure that:
 - reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk;
 - they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm; and
 - they open ACCT procedures when indicated.
- The Governor and Head of Healthcare should ensure that all staff are aware of the need to refer any prisoner with a disability to the Equalities Officer to ensure that reasonable adjustments are made in line with PSI 2011/32.
- The Governor should review the operation and management of F wing, and, in particular ensure that:
 - officers have meaningful contact with prisoners during their first weeks in custody, including individual conversations that allow them to get to know prisoners and identify their needs;
 - all significant information, especially that which could reflect a prisoner's risk to themselves or others, is accurately recorded and acted on and intelligence reports are submitted when necessary; and
 - effective measures are in place to reduce the supply of illicit substances.
- The Head of Healthcare should ensure that staff attempt to obtain a prisoner's community GP records, where relevant, on arrival at the prison.
- The Head of Healthcare should ensure that there is a robust system to ensure that a prisoner's clinical records are accurate and not duplicated.
- The Head of Healthcare should ensure that clinical care, the level of observations and review for prisoners detoxifying from drugs and alcohol adhere to the local policies.
- The Head of Healthcare should ensure that staff make timely referrals for prisoners to the mental health team where appropriate.
- The Head of Healthcare should ensure that assessment for, prescription of and review of a prisoner's progress on medication follows NICE guidelines, including the associated record keeping.

The Investigation Process

17. 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.
18. The investigator visited Pentonville on 5 March. She obtained copies of relevant extracts from Mr Givans' prison and medical records.
19. The investigator interviewed ten members of staff and two prisoners at Pentonville in March and April. She interviewed an additional member of staff in July via videolink.
20. NHS England commissioned two clinical reviewers to review Mr Givans' clinical care at the prison. One of the clinical reviewers conducted joint interviews with the investigator.
21. We informed HM Coroner for Inner North London of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
22. One of the Ombudsman's family liaison officers contacted Mr Givans' mother, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She wanted to know why Mr Givans had not moved wings after her visit on 21 February when she had been told by an officer that he would be moved from his cell that day.
23. Mr Givans' mother received a copy of the initial report. The solicitor representing Mr Givans' mother wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised 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.
24. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Pentonville

25. HMP Pentonville is a local prison that holds over 1,200 young adult and adult men. The prison primarily serves the courts of north and east London.
26. 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 day care facility for patients with mental health problems who are managed on the wings. There is a detoxification wing where prisoners receive support and treatment as appropriate from Building Futures, the substance misuse service. Nurses and managers specialising in drug withdrawal treatment are also based on the wing.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Pentonville was conducted in January 2017. Inspectors reported that the quality of ACCT documents was generally poor with very limited caremaps, inconsistent case management, and observations completed at predictable intervals. They found that there had been some proactive measures to address levels of disorder and to limit the supply of drugs in the prison, although drug availability remained high. Inspectors found that support for prisoners with substance misuse problems was well developed. They also found that staff-prisoner relationships had improved since their last inspection. However, inspectors had significant concerns about safety in the prison. 70% of prisoners said they had felt unsafe at some time.

Independent Monitoring Board

28. 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 2018, the IMB reported that Pentonville had been short staffed for most of the year resulting in prisoners being locked in their cells for longer. The board noted the commitment of many staff was hampered by difficulties with drugs and mobile phones coming into the prison, overcrowding and the need for improvements to the structure and cleanliness of the prison.

Previous deaths at HMP Pentonville

29. Mr Givans was the fourteenth prisoner to die at Pentonville since August 2015, and the eighth to take his own life. Our reports into deaths of prisoners in 2016 and 2017 found that staff did not consider all risk factors when determining a prisoner's risk to themselves. The report into a death of a prisoner in 2016 also found that more meaningful interaction needed to take place between prisoners and wing staff.

Assessment, Care in Custody and Teamwork

30. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should

be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive substances (PS)

31. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
32. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
33. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

34. On 7 February 2018, Mr Givans appeared at court and was remanded into custody for an offence of possession of a knife at his ex-partner's flat. He was also in breach of a restraining order preventing him from having contact with his ex-partner. His case was committed to the Crown Court and his next appearance was listed for 7 March.
35. A custody officer at court completed a suicide and self-harm warning form, which she forwarded to the prison. She recorded that Mr Givans had a history of self-harm within the last six months. Mr Givans told her that he had felt low at the police station but felt better at court. He was kept under constant observation at court. The Person Escort Record (PER) which accompanied Mr Givans from court to prison noted that Mr Givans had told a police officer on 6 February that he would self-harm if remanded into custody. The PER also noted that Mr Givans had had previous thoughts of suicide in 2014, was profoundly deaf but could lip-read, misused alcohol and cannabis, and suffered from depression.
36. Mr Givans was taken to HMP Pentonville where Officer A assessed him. Mr Givans told him he was deaf but could lip-read and he could speak such that the officer could understand him. The officer asked Mr Givans about his statement that he would self-harm if taken to prison. Mr Givans said he had been on a constant watch in prison a long time ago due to his risk to himself. He said he had no current thoughts of suicide or self-harm, nor had he had any before coming to prison. The officer was aware that this conflicted with the information in the PER but, in a statement given to the safer custody department, said that he believed Mr Givans when he said he felt calm and settled.
37. Nurse A assessed Mr Givans. Mr Givans said he was deaf and did not have his hearing aids but could communicate by lip-reading. Mr Givans told the nurse that he was anxious and wanted medication for this. The nurse recorded "*requested to be seen by the mental health team*". The nurse told the investigator that he could not remember if this meant that Mr Givans had asked to see the mental health team or if he had asked the mental health team to see Mr Givans. He said he thought he had referred Mr Givans to the mental health team. There is no evidence that he did so.
38. Mr Givans told Nurse A that he had misused alcohol for 15 years and last drank alcohol the day before. Mr Givans also told him that he had smoked crack cocaine daily in the past. The nurse said he did not complete a drug test, since there was no treatment available for cocaine. Mr Givans scored ten on the Alcohol Use Disorders Identification Test (AUDIT), indicating harmful alcohol use. The nurse told the investigator that Mr Givans had mild withdrawal symptoms. The nurse referred Mr Givans to the GP and substance misuse services.
39. Nurse A also recorded that Mr Givans needed hearing aids for both ears. He told the investigator that, at the time, he did not regard this as an issue which made Mr Givans more vulnerable than other prisoners.
40. Nurse A said that he usually had access to PERs when assessing prisoners. He could not remember if he had read Mr Givans' PER and seen the information that he would harm himself if he was remanded to prison. He said that he did not request Mr Givans' community records as he was not receiving medication. The

nurse noted that Mr Givans seemed settled, calm and said he had no thoughts of suicide or self-harm. The nurse did not consider it was necessary to start ACCT procedures.

41. At 6.44pm, Dr A, GP, assessed Mr Givans. He noted that Mr Givans drank up to 54 units of alcohol per day, had a history of anxiety and depression and did not have his hearing aids. Mr Givans said he used cannabis daily and crack cocaine occasionally – the last time being two weeks earlier. The doctor prescribed medication to try to minimise Mr Givans' symptoms of alcohol withdrawal. He did not consider any adaptations to address Mr Givans' deafness but said he would liaise with healthcare administration to try to obtain his hearing aids.
42. On 8 February, at 1.15am, Nurse B gave Mr Givans his medication in his cell. Mr Givans said that he was okay. The nurse checked on Mr Givans again at 3.15am and 5.45am. He appeared to be asleep on both occasions.
43. Dr B, GP, mainly works on F wing, the detoxification wing, where Mr Givans was located. Shortly before 9.00am, the doctor met Mr Givans in his wing office. Mr Givans told him that he was deaf but the doctor did not consider any adaptations to accommodate his deafness. He tried to access Mr Givans' medical records but could find no reference to him. He said, on reflection, that this should have concerned him but did not at the time, perhaps due to time pressure as there was generally a queue of prisoners waiting outside his office to see him. It was only after Mr Givans' death that the doctor found out that Mr Givans had another medical record with a slightly different spelling of his name, and a different year of birth and prisoner number.
44. Mr Givans told Dr B that he had been seen the night before and that same morning by the substance misuse service. He said that he had been prescribed medication the night before to try to minimise the symptoms of his withdrawal from alcohol. Mr Givans said that he was homeless in the community and drank eight to ten cans of cider daily. Mr Givans said that he felt depressed and the doctor prescribed a low dose of sertraline (an antidepressant).
45. Dr B told the investigator that he had done a more thorough assessment of Mr Givans' than he had recorded. He said that Mr Givans had seemed sad. The doctor said that when he is assessing a prisoner's mood, he always asks prisoners if they have any thoughts of suicide and self-harm. For this reason, he is confident that he would have asked Mr Givans this. He thought that he probably did not record the answer as Mr Givans replied that he did not. The doctor said that if he had had concerns that Mr Givans was a risk to himself he would have recorded it.
46. On 9 February, Nurse C noted that she completed Mr Givans' night check through the observation panel and he appeared to be asleep. She noted the same thing at the morning check at 5.43am. On 12 February, the substance misuse manager, noted that Mr Givans' five-day review for alcohol detoxification had been booked.
47. Prisoner A, shared a cell with Mr Givans throughout his time at Pentonville. He said that Mr Givans could lip-read and understood about 50% of what he said to him. He often wrote things down to communicate with him. He said he never saw staff write anything down to assist in communicating with Mr Givans. The prisoner said that Mr Givans gave his shoes to another prisoner in the first week

he was at Pentonville as payment for something. He said that an officer returned them to Mr Givans the next day.

48. Another prisoner, prisoner B, lived in the next cell to Mr Givans. He said that Mr Givans seemed generally well and he never had any concerns that he was a risk to himself. The prisoner said Mr Givans smoked PS daily from his arrival at the prison and gave prisoners his canteen and tobacco to pay for it. However, the prisoner said he did not believe Mr Givans was in debt or unable to pay for the PS and thought his cellmate would have helped Mr Givans if he needed it. The prisoner said he thought Mr Givans had mental health issues as he did not seem "right in the head". He said Mr Givans spoke to a small number of prisoners during association.
49. On 13 February, the substance misuse case manager, noted that she had discussed harm reduction with Mr Givans. Mr Givans said he was motivated to change for himself and his daughter, who he had not seen for a year. He wanted to find accommodation and employment. He said he misused cannabis, crack cocaine and alcohol and was homeless in the community. Mr Givans said that he wanted to go to rehabilitation to address his alcohol issues. Mr Givans said he had never self-harmed but suffered from anxiety and depression. The substance misuse case manager was concerned that Mr Givans did not have his hearing aids. She noted that she would contact Mr Givans' solicitor and mother to try and arrange for them to bring them in. The outcome of this contact is not recorded.
50. On 14 February, an offender resettlement worker, assessed Mr Givans. She said that he could lip-read and communicate verbally. He said he was a drug and alcohol user and wanted to engage with substance misuse services. He also said that he suffered from depression and anxiety but was not taking any medication. The offender resettlement worker said she did not know that he had been prescribed antidepressants. He said he had no thoughts of suicide or self-harm. She told the investigator that she had no concerns Mr Givans was using PS.
51. On 16 February, Nurse D completed Mr Givans' secondary health screen. This is normally done within seven days of a prisoner's arrival and was therefore two days late. The nurse said she would usually check a prisoner's initial health screen but she could not find one for Mr Givans on the system. (Again, this was because he had two sets of medical records.) His physical observations were normal. The nurse referred him to a GP as Mr Givans said he had a lump on his throat.
52. Nurse D completed a health assessment questionnaire with Mr Givans which asked him questions about how he was feeling. He scored five on this questionnaire. The nurse said if he had scored six or more she would have referred him to the mental health team. She said she did not have any concerns that Mr Givans presented a risk to himself or was using PS. She was not aware that Mr Givans was deaf until the end of their appointment. She did not consider whether any adjustments were necessary as a result.
53. Mr Givans' aunt visited him on 19 February. Mr Givans' mother told the PPO's Family Liaison Officer that Mr Givans told his aunt that he was not happy on his current wing as there were lots of drugs available there. He also told his aunt

that he did not have his hearing aids and felt vulnerable as a result. His aunt reassured him and told him that his mother would be visiting on 21 February. His aunt said she told officers in the visiting hall that Mr Givans was a vulnerable adult and asked them to “watch out” for him.

54. Also on 19 February, Mr Givans’ five-day review, which was part of his substance misuse treatment, was booked for the following day.
55. Prisoner, Mr Givans’ cell mate, said that Mr Givans was smoking PS. He said that Mr Givans started acting strangely and seemed paranoid after he had been at Pentonville for around two weeks. He said Mr Givans believed that the government and officers were planning something against him, or that someone was following him, and he sometimes rang his cell bell and asked officers to confirm he was safe. The prisoner said that Mr Givans did not sleep well and often seemed to watch television for most of the night. The prisoner said that during association Mr Givans tended to remain standing in front of their cell. He did not know why.
56. On 20 February, Mr Givans five-day review did not take place as scheduled. Staff recorded that they could not gain access to Mr Givans.
57. On 21 February, Mr Givans’ mother visited him. She told the operational support grade (OSG), that she had one of Mr Givans’ hearing aids and asked if she could give it to him. (Mr Givans needed hearing aids for both ears but his mother had only been given one). The OSG told her that she would find out and let her know. In the meantime, Mr Givans met his mother. He told her that he was unhappy living on his current wing and cell, there were lots of drugs available and he did not feel safe. He said that his mattress had been slashed when he was out of his cell but he had not reported this to staff. Mr Givans said that he was worried about not having his hearing aids, since he would not hear anyone coming into his cell if he was asleep. His mother said she would speak to an officer and leave his hearing aid with them.
58. On her way out, Mr Givans’ mother told the, OSG that her son wanted to move to another wing. The OSG took Mr Givans’ hearing aid from her and said she would call her later about her son’s concerns and the hearing aid.
59. Having gained authorisation to give Mr Givans his hearing aid, the OSG later went to F wing and handed it to Mr Givans. She recorded that he was very grateful. He came out of his cell and told her that he wanted to move cells as he did not feel comfortable with his cellmate. He said that his mattress had recently been slashed as if someone was trying to hide something inside it. He also said that he believed his cellmate had looked through his paperwork and other belongings.
60. The OSG then went with Mr Givans to speak to Supervising Officer (SO) A who worked on the wing. The OSG said that Mr Givans repeated his concerns to the SO and the SO telephoned the prison’s population management function to see if he could be transferred to another cell. She was told there was no space. The OSG said that SO A said she would try and move Mr Givans by the end of the day, or as soon as a space was available. The OSG then left the wing and telephoned Mr Givans’ mother to update her. Mr Givans’ mother said the OSG told her that Mr Givans would move wings later that day. The OSG’s version of

events is slightly different in that she said that she told Mr Givans' mother that staff were trying to allocate him another cell.

61. SO A told the investigator that Mr Givans had asked to move to another cell, not to another wing. She said that he did not say he felt unsafe but just wanted to move cells. She said that Mr Givans had said he was concerned that his cellmate could slash his mattress and she told him that this could happen in any cell. The SO said that Mr Givans did not tell her that this had already happened. She told the investigator that she advised Mr Givans to speak to officers on the wing. The SO said that she did not phone population management. She said that Mr Givans did not appear concerned.
62. On 22 February, Dr B assessed Mr Givans due to the concern he had about a lump in his neck. The doctor completed a physical examination and had no concern about the lumps, which he believed to be lymph nodes. To be sure, however, he ordered blood tests and intended to review Mr Givans once these were completed. The doctor did not remember Mr Givans from their last meeting and therefore did not review his mental health.

26 February

63. At 6.30am on 26 February, an officer woke prisoner A as he had to attend court. Mr Givans was already awake and asked prisoner A why he had not told him he was going to court and whether he was going to come back. Prisoner A said he did not know. He told the investigator that Mr Givans seemed "fine". Prisoner A said he never had any concerns that Mr Givans was a risk to himself.
64. At 11.41am, Dr C, GP, noted in Mr Givans' medical record that his five-day review was booked for the following day.
65. The investigator reviewed the cell bell records. Mr Givans rang his cell bell seven times during the day. This was more than usual but it was also unusual for Mr Givans to be alone in his cell all day. Staff answered all the cell bells within a few minutes. The last bell was at 5.09pm which Officer B responded to. The officer said she spoke to Mr Givans through his observation panel. Mr Givans asked her if he was going to get a "nicking" or was in trouble. The officer said she was not aware of anything as she had not been working on his landing that day. She asked him if he had received any warnings and he said he had not. The officer said he seemed fine with this and did not ask any further questions.
66. Officer C started to complete the roll check around 5.00pm. She told the investigator that when she got to Mr Givans' cell, he was trying to tell her something but, as she could not understand what he was saying, she unlocked his cell door. She said she thought he had a speech impairment. Mr Givans asked her to get him a new prison identification card. She asked what had happened to his own card and he said that as he had two different prisoner numbers he did not have one. She told Mr Givans that she was working on the wing again the following day so she would try and get him an identification card in the morning. She said she asked Mr Givans if this was alright and he gestured with a thumbs-up to her, smiled and said, "Yes miss, that's fine." The officer said that Mr Givans seemed fine, she had no concerns about him and re-locked his cell.

67. Prisoner A returned from court around 6.00pm. Officer D escorted him from reception to his cell at 6.37pm. When the officer unlocked the door, he saw Mr Givans had hanged himself from the bed guard on the top bunk using a bedsheet. He was slouched with his head on the top bunk and his feet on the floor. The officer used his anti-ligature knife to try to cut through the ligature while the prisoner supported Mr Givans' weight. The officer was unable to cut the ligature because of its size and thickness. At 6.39pm he radioed that a prisoner was hanging and gave the cell location. The control room officer radioed a code blue emergency, which indicates that a prisoner is unconscious or having breathing difficulties. He telephoned for an ambulance.
68. Officer C and Supervising Officer (SO) B arrived at the cell while the officer was still cutting the ligature. The SO tried to cut the ligature from a different angle and managed to do so after about 30 seconds. As he was moving Mr Givans out of the cell, the healthcare officer arrived, checked for signs of life and advised the SO to start chest compressions. Other staff arrived and assisted. At 6.43pm healthcare staff attached a defibrillator, inserted an airway and administered oxygen using a mask. Paramedics arrived at 6.47pm and continued with Mr Givans' treatment with the assistance of prison staff. At 7.24pm paramedics pronounced Mr Givans dead.

Contact with Mr Givans' family

69. Officer E was appointed as the family liaison officer. She went to Mr Givans' mother's address, arriving at 11.20pm. Mr Givans' aunt answered the door; his mother was not in. Mr Givans' aunt would not disclose where his mother was so the officer broke the news of Mr Givans' death to his aunt. The officer telephoned Mr Givans' mother and broke the news of her son's death and offered her condolences. She offered to visit Mr Givans' mother that evening but they agreed she would visit her the next day. The officer remained in contact with her and offered financial assistance with Mr Givans' funeral in line with prison service instructions.

Support for prisoners and staff

70. After Mr Givans' death, the duty Governor, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
71. The prison posted notices informing other prisoners of Mr Givans' 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 Givans' death.
72. Support was arranged for prisoner A. He was offered a Listener (a prisoner trained by the Samaritans to offer support to other prisoners) before being located to a new cell, was referred to the mental health team and staff opened an ACCT. Although prisoner A told us that he did not feel adequately supported, we are satisfied that the prison offered him appropriate support.

Post-mortem report

73. The post-mortem report indicated that Mr Givans' cause of death was suspension by ligature. The toxicology report indicated that Mr Givans had used cocaine regularly in the five months before his death. No PS were detected.

However, it is noted in the report that only six of the more common types of PS were tested for and over 100 different types have been identified.

Findings

Identifying risk of suicide and self-harm

74. Prison Service Instruction (PSI) 64/2011, *Safer custody*, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as being at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Pentonville should have recognised Mr Givans as being at risk and begun ACCT procedures to support him.
75. Mr Givans had some risk factors for suicide and self-harm when he arrived at Pentonville. He had attempted suicide and self-harmed in the past, he was withdrawing from alcohol, had a recent history of drug misuse, had mental health issues, was charged with offences against his ex-partner, and, when in police custody, had said he would self-harm if remanded to prison. He was also deaf which could increase his vulnerability.
76. Nurse A told the investigator that he had no concerns that Mr Givans' presented a risk to himself and would have opened an ACCT if he had. He said that Mr Givans had good eye contact, was calm and settled. The nurse said that Mr Givans presented well during their assessment and he did not know why Mr Givans was in prison. He could not remember whether he had read the information on the PER that Mr Givans had said he would harm himself if remanded into custody.
77. Mr Givans told Officer A that he had never had any thoughts of suicide or self-harm. The officer was aware that this conflicted with the information in the PER but said he believed Mr Givans when he said he felt calm and settled.
78. Neither Nurse A nor Officer A considered how Mr Givans' deafness might increase his vulnerability in prison.
79. We are concerned that Nurse A and Officer A did not give sufficient weight to Mr Givans' risk factors, including his recent thoughts of self-harm, when considering his risk. Instead, they relied too much on what he said to them at the time. While this is important, a PPO thematic report about risk factors in self-inflicted deaths, published in April 2014, found that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour.
80. We consider that reception staff at Pentonville should have been more alert to Mr Givans' risk factors for suicide and self-harm. While this would not have automatically led them to open ACCT procedures, it should at least have been considered in the light of his ongoing risk factors. It may also have assisted in identifying Mr Givans' vulnerability at an earlier stage and identifying the support that he required in prison. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk:**
- **they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm; and**
- **they open ACCT procedures when indicated.**

Mr Givans' disability

81. Mr Givans was born deaf and needed hearing aids in both ears but was competent at lip-reading. However, the clinical reviewer noted that even the most competent lip-readers are estimated to understand around only 50% of what is said.
82. PSI 2011/32, *Ensuring equality*, indicates that Governors must ensure that reasonable adjustments are made for disabled prisoners to avoid them being at a disadvantage. A reasonable adjustment is "an adaptation to change a provision, criterion or practice, or to change a physical feature, or to provide auxiliary aids or services in order to avoid placing a disabled person at a substantial disadvantage." The PSI indicates that, in prison, a reasonable adjustment should enable a disabled prisoner to take a full part in the normal life of the establishment.
83. No one considered how Mr Givans' deafness made him more vulnerable in prison or what adjustments might need to be made. In addition, Mr Givans did not have his hearing aids for two out of the three weeks he was in Pentonville. Although healthcare staff noted this, it is not clear what, if any, actions they took to address the situation. Mr Givans' family quickly provided one of his hearing aids once they were aware he did not have them. No efforts were made to obtain his second hearing aid, nor were staff apparently aware that he still needed this. He had told his aunt that he feared for his own safety as he could not hear prisoners entering his cell.
84. Officer F is the Equalities Officer in Pentonville. He was unaware of Mr Givans until after he died. He said that it was a "massive failure" that Mr Givans had not been referred to him. He said that if Mr Givans been referred to him, he would have gone to see him within three days of his arrival. He would have contacted Mr Givans' mother and met her outside the prison to collect his hearing aids immediately. He would have considered whether any other actions needed to be taken, such as an evacuation plan for Mr Givans in the event of an emergency. He said he would also have liaised with external agencies for assistance and had a minicom which Mr Givans could have used to communicate with his family. This is a small electronic typewriter and screen linked to a telephone system, which enables people with hearing or speech difficulties to send and receive messages. Since Mr Givans could not use the telephone, the officer would have also arranged extra visits, or videolink appointments. The officer could also have helped Mr Givans to get an appropriate job in the prison, potentially within his first week of being there. Pentonville also has a member of staff who is trained in sign language.

85. The service offered by Officer F could have assisted in reducing Mr Givans' isolation and sense of vulnerability. The officer said that since Mr Givans' death, he has placed guidance for staff in reception. He has also reminded reception staff via email of prisoners who should be referred to him. However, we remain concerned that no staff, not just those in reception, considered referring Mr Givans to Officer F. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of the need to refer any prisoner with a disability to the Equalities Officer to ensure that reasonable adjustments are made in line with PSI 2011/32.

Mr Givans' location in Pentonville

86. Mr Givans was in the same cell on the detoxification wing throughout his time at Pentonville. Mr Givans told his mother that he felt unsafe in his cell and she said that she had been assured by staff that Mr Givans would be moved between wings. She was distressed to discover that this had not occurred before he died.
87. The OSG said that Mr Givans had told SO A about his concerns for his safety and that he wished to move cells, and that the SO had phoned the population management unit and had said that she would arrange a move as soon as possible. The OSG did not note this information in Mr Givans' record or submit an intelligence report.
88. SO A told the investigator that Mr Givans had spoken to her, said he wanted to move cells not wings, but not because he had any concerns. She also said she did not ring the population management unit. She did not make a record of her conversation with Mr Givans.
89. It is impossible to verify either version of events. It is a cause for concern that none of this information, which was crucial to Mr Givans' feelings of isolation and vulnerability, was noted in Mr Givans' record or in the wing observation book. What is clear is that no move of any description took place.

Psychoactive substances

90. Staff told us that they were not aware of Mr Givans using PS and that they had not seen him under the influence of PS. However, the two prisoners we spoke to were clear that Mr Givans was using PS for at least some of his time at Pentonville. It was not possible to verify the suggestion that Mr Givans had been in debt and that a staff member retrieved his trainers from another prisoner, although both should certainly have raised concerns and been recorded if they occurred.
91. The toxicology report did not detect any PS in Mr Givans' system. However, this only tested for six of the more common types of PS out of over 100 types that have been identified. Given Mr Givans' background of substance abuse, we do not consider that we can rule out the possibility that Mr Givans was using PS at Pentonville and may have done so in the period before his death.

Personal officer scheme/meaningful contact

92. Mr Givans did not have a personal officer and there is little evidence of significant one-to-one contact with wing staff. This is particularly important in the first weeks

in custody and, without such contact, it is more difficult for staff to identify whether a prisoner has any issues or might be more vulnerable to suicide and self-harm. This would have been particularly helpful for someone like Mr Givans who had a range of risk factors, including his deafness.

93. Following a death in custody in 2016, Pentonville indicated that they planned to introduce a personal officer scheme. In January 2017, HM Inspectorate of Prisons noted that a personal officer scheme had recently been introduced but was not yet fully embedded. However, the custodial manager, told us that there was no personal officer scheme at Pentonville at the time of Mr Givans' death in February 2018.
94. We note that Pentonville is due to start implementing the new offender management model in January 2019 as part of a national roll-out. Under the new model every prisoner will have a keyworker who will be his first point of contact and assist him with any difficulties he is having in prison.
95. However, given the range of concerns we have identified in the course of this investigation, we think more immediate action needs to be taken. We are particularly concerned at the lack of evidence of effective interaction with prisoners on F wing and the poor quality of documentation. We are also very concerned at the suggestion that drugs are easily accessible, given the wing's function.
96. We make the following recommendation:

The Governor should review the operation and management of F wing, and, in particular ensure that:

- **officers have meaningful contact with prisoners during their first weeks in custody, including individual conversations that allow them to get to know prisoners and identify their needs;**
- **all significant information, especially that which could reflect a prisoner's risk to themselves or others, is accurately recorded and acted on and intelligence reports are submitted when necessary; and**
- **effective measures are in place to reduce the supply of illicit substances.**

Clinical Care

97. The clinical reviewer concluded that Mr Givans' clinical care was not equivalent to that which he could have expected to receive in the community. The reasons for this are outlined below.

Obtaining clinical records

98. Nurse A did not request Mr Givans' community GP records. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, instructs that staff should try to get relevant information from a prisoner's community GP. The nurse said that he does not request these unless a prisoner is receiving treatment. The clinical reviewer concluded that this omission was a lost opportunity to gain further information about Mr Givans' deafness and the impact

that this had on his daily living. The community GP medical records should have been obtained. We make the following recommendation:

The Head of Healthcare should ensure that staff obtain prisoners' community GP records on arrival at the prison.

Record keeping

99. Mr Givans had two separate medical records. This was not identified until after he died. This presented a risk to his care and should have been picked up earlier. We make the following recommendation:

The Head of Healthcare should ensure that there is a robust system to ensure that a prisoner's clinical records are accurate and not duplicated.

Alcohol detoxification

100. Mr Givans was appropriately prescribed medication to lessen his withdrawal symptoms from alcohol. The Deputy Head of Healthcare, said that he would expect a prisoner withdrawing from alcohol to be observed three to four times a night for at least the first five days he is in prison. This did not occur. In addition, the review which should happen five days after a prisoner has started detoxification treatment was rebooked several times and had not taken place before Mr Givans' death. We make the following recommendation:

The Head of Healthcare should ensure that clinical care, the level of observations and review for prisoners detoxifying from drugs and alcohol adheres to the local policy.

Mental Health Care

101. Nurse A told the investigator that he thought he had referred Mr Givans to the mental health team after Mr Givans told him he was anxious and depressed. There is no evidence that he did so. This was a missed opportunity to assess Mr Givans more thoroughly. We make the following recommendation:

The Head of Healthcare should ensure that staff make timely referrals for prisoners to the mental health team where appropriate.

102. The clinical reviewer concluded that Dr B prescribed Mr Givans antidepressant medication without adequately documenting the clinical rationale for this decision. In addition, the doctor did not arrange an appointment to review Mr Givans, in line with NICE (the National Institute for Health and Care Excellence) guidance. This recommends an initial review two weeks after prescribing antidepressants.
103. Dr B could not account for this, other than the pressures of time. He said that he would usually review a prisoner within 5-7 days of prescribing them antidepressants. The Deputy Head of Healthcare said these issues had already been raised with Dr B, and Dr B told the investigator that he had already reflected on and acknowledged the shortcomings of his own practice. We make the following recommendation:

The Head of Healthcare should ensure that assessment for, prescription of and review of a prisoner's progress on medication follows NICE guidelines, including the associated record keeping.

