

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert Ginn a prisoner at HMP Pentonville on 29 November 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 we oversee can improve their work in the future.

Mr Robert Ginn was found hanged in his cell on 29 November 2018 at HMP Pentonville. He was 56 years old. I offer my condolences to Mr Ginn's family and friends.

Staff at Pentonville were monitoring Mr Ginn under Prison Service suicide and self-harm prevention procedures when he died. However, I consider that they underestimated his risk of suicide and failed to put adequate measures in place to reduce his risk. Staff also failed to carry out observations at the agreed level of frequency. I am also concerned that mental health staff failed to attend two out of four of his case reviews.

Mr Ginn's mental health deteriorated a few days before his death. The clinical reviewer found that the standard of care he received was not equivalent to that he could have expected to receive in the community.

There was a delay in the emergency response because the member of staff who found Mr Ginn failed to call a medical emergency code and waited for other staff to arrive before entering his cell. Once a code was called, the prison's control room did not immediately call for an ambulance as they should have done. Although these failings did not affect the outcome for Mr Ginn, the prison needs to address them.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**August 2019**

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# Summary

## Events

1. On 5 November 2018, Mr Robert Ginn was sentenced to 12 months imprisonment for sexual offences. He was sent to HMP Pentonville.
2. The following day, a nurse started Prison Service suicide and self-harm monitoring (known as ACCT), after Mr Ginn told her he was having thoughts of suicide.
3. On 20 November, a senior mental health practitioner saw Mr Ginn for a mental health assessment. When asked what support he wanted, Mr Ginn said that he wanted some morphine to take his life. Mr Ginn said he had plans to kill himself but would not tell her or she would stop his plans. He also said that he received some support from his youngest daughter and a female friend. The practitioner planned for Mr Ginn to continue with his prescribed medication and for the primary care mental health team to review him within two weeks.
4. On 26 November, a psychiatrist saw Mr Ginn for a mental health assessment. Mr Ginn joked about his previous episodes of self-harm and that he would be better off being stabbed by another inmate. Mr Ginn said that his daughters and a female friend were protective factors and that he was scared of dying. The psychiatrist diagnosed Mr Ginn with an adjustment disorder (a stress-related condition). The psychiatrist decided to increase Mr Ginn's antidepressant prescription, referred him for cognitive behaviour therapy and planned to see him before the Christmas holidays.
5. At 3.30pm on 28 November, an officer spoke to Mr Ginn, who said he was "in a very bad way". Mr Ginn said that he had nothing to live for, would be better off dead and that he was upset because a female friend had accused him of lying to her about his crimes.
6. Just after 1.00am on 29 November, an operational support grade (OSG) began checking on certain prisoners and, when she reached Mr Ginn's cell, she saw that he had tied a ligature around his neck. She called to another OSG for help. The second OSG called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) at 1.08am but neither of them entered Mr Ginn's cell. Four prison officers and two nurses quickly responded. They entered the cell, removed the ligature and started cardiopulmonary resuscitation (CPR).
7. At 1.10am, an officer called for an ambulance and paramedics reached Mr Ginn at 1.24am. The paramedics were unable to resuscitate Mr Ginn and, at 2.10am, declared that he had died.

## Findings

### Assessment of Mr Ginn's risk of suicide and self-harm

8. Staff underestimated Mr Ginn's risk of suicide and self-harm by not placing sufficient weight on his regular suicidal comments, his deteriorating mental health

and his previous suicide attempts while in the community. We are also concerned that staff were not aware of the significance of the breakdown in Mr Ginn's relationship with a friend and that this did not result in an immediate ACCT case review.

9. We also found other deficiencies with the ACCT process. The gaps between ACCT case reviews were too long, mental health staff did not attend two of the four reviews, and staff regularly failed to observe him as specified – on one occasion, he was not checked for five hours and 30 minutes when he should have been checked every two hours.

### **Reception**

10. When Mr Ginn arrived at Pentonville, we are concerned that staff did not immediately place him on an ACCT because he arrived with a form warning he was at risk of suicide and self-harm and he made comments about feeling suicidal.

### **Mental health**

11. Mr Ginn's mental health deteriorated while at Pentonville and the clinical reviewer considered that, from 26 November, his care should have been transferred to the inreach mental health team. The clinical reviewer considered that Mr Ginn's mental health care was not equivalent to that which he could have expected to receive in the community.

### **Emergency response**

12. When the OSG found Mr Ginn hanging, she did not call a code blue emergency or enter his cell. When the second OSG called the code blue, the control room did not immediately call an ambulance as they should have done.

### **Family liaison**

13. We are concerned that the record of Mr Ginn's next of kin was not updated, which meant that his sister rather than his wife was contacted after he died. We are also concerned that the police broke the news of his death rather than the prison.

### **Staff support**

14. We are concerned that, following Mr Ginn's death, the OSG who had found him stayed on the same wing that night and that the officer actively involved in the resuscitation attempt led the hot debrief. We are concerned that both episodes displayed a lack of care and support towards staff.

## Recommendations

- The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they:
  - consider all risk factors, including suicidal statements, apparent planning and previous suicide attempts, when assessing a prisoner's risk;
  - schedule case reviews at appropriate intervals, in line with the prisoner's level of risk;
  - hold multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care;
  - adhere to the frequency of observations set out in the ACCT document and that observations take place at unpredictable times;
  - record details of protective factors and potential triggers in the ACCT document;
  - involve the prisoner's family when that would be appropriate.
- The Governor and the Head of Healthcare should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with documents detailing a risk of suicide and self-harm, they should clearly record the reasons.
- The Head of Healthcare should ensure that there is effective and clear liaison between the primary care mental health team and the mental health inreach team, which allows a prisoner's suitability for each mental health team to be promptly reassessed.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
  - staff enter cells as quickly as possible in a life-threatening situation.
  - staff radio an appropriate emergency code.
  - control room staff call an ambulance as soon as an emergency code is called.
- The Governor should ensure, in line with PSI 64/2011, that:
  - when a prisoner changes their next of kin, staff update the prisoner's NOMIS prison record promptly; and
  - a family liaison officer breaks the news of a death to a next of kin in person as soon as possible.
- The Governor should ensure that, following a death in custody, staff receive adequate support and that a manager, not involved in the death, leads a hot debrief and records who attends.

## The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.
16. The investigator visited Pentonville on 4 December 2018. He obtained copies of relevant extracts from Mr Ginn's prison and medical records.
17. NHS England commissioned two clinical reviewers to review Mr Ginn's clinical care at the prison.
18. The investigator interviewed 11 members of staff at Pentonville on 29 January, 19 February and 20 February. The investigator also interviewed three members of staff by telephone on 7 February, 28 February and 1 April and one prisoner by video link on 27 March. A clinical reviewer accompanied the investigator for the interviews on 20 and 28 February and, a colleague of both clinical reviewers, accompanied the investigator for one of the interviews on 19 February.
19. We informed HM Coroner for Inner North London of the investigation. The coroner gave us the results of the post-mortem and toxicology examinations. We have sent the coroner a copy of this report.
20. The investigator contacted Mr Ginn's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Ginn's sister did not ask any questions but provided statements that recorded the dealings that she and one of Mr Ginn's friends had had with him while at Pentonville.
21. The investigator also wrote to Mr Ginn's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know:
  - Why had the prison not contacted her when Mr Ginn died despite her being the nominated next of kin?
  - What mental health care had Mr Ginn received, including what assessments had been carried out, what medication had been prescribed and what observations had been made?
22. 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.
23. The solicitor representing Mr Ginn's sister received a copy of the initial report. They did not make any comments.
24. Mr Ginn's wife received a copy of the initial report. She did not make any comments.

# Background Information

## HMP Pentonville

25. HMP Pentonville is a local prison that holds over 1,200 young adult and adult men, though the operational capacity is temporarily reduced to allow the prison to refurbish its wings. The prison primarily serves the courts of north and east London.
26. Care UK, in partnership with Enfield and Haringey Mental Health Trust, provides healthcare services. 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.

## HM Inspectorate of Prisons

27. The most recent inspection of HMP Pentonville was in January 2017. Inspectors found that ACCT case management showed major weaknesses, which included poorly completed documents, limited caremaps, inconsistent case management and incomplete observations. They found that there was no quality assurance of ACCTs and that prisoners on ACCTs did not feel adequately cared for or supported.
28. Inspectors also found that primary mental health services had improved and were sufficient, with a rich mix of skills among the range of mental health professionals. They found that prisoners with mental health problems were promptly assessed.

## Independent Monitoring Board

29. 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 the number of ACCTs being opened had decreased and that additional Safer Custody staff allowed a more meticulous approach to opening and documenting ACCTs. They found that the reception process generally worked well and that a triage system identified those prisoners at risk of self-harm or substance misuse.

## Previous deaths at HMP Pentonville

30. Mr Ginn was the seventh prisoner to die at Pentonville since November 2016. Of the previous deaths, two were due to natural causes and four were self-inflicted. We have made previous recommendations about ensuring ACCT procedures and emergency responses are managed in line with national guidance.

## Assessment, Care in Custody and Teamwork

31. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.

32. 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 multidisciplinary 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.
33. 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, *Management of prisoners at risk of harm, to self, to others and from others (Safer Custody)*.

## Key Events

34. On 5 November 2018, Mr Robert Ginn was sentenced to 12 months imprisonment for various sexual offences. He was sent to HMP Pentonville.
35. At 1.16pm on 5 November, prior to transferring from Snaresbrook Crown Court to Pentonville, an escorting officer completed the risk indicator page on Mr Ginn's Person Escort Record (PER - a form that accompanies prisoners when they transfer between police custody, courts and prisons, which sets out the risks they pose) and recorded "yes" in the risk of suicide and self-harm box. The escorting officer did not provide any further details.
36. At 6.37pm, a nurse saw Mr Ginn for an initial health assessment and recorded that he had not self-harmed or attempted suicide within the last 12 months. Mr Ginn said that he had a history of depression, high blood pressure and diabetes. The nurse referred Mr Ginn to a prison GP for a review.
37. At 6.57pm, a nurse saw Mr Ginn for a clinic assessment. Mr Ginn said that he had deliberately hurt himself with a scalpel in September and that a hospital psychiatric team offered to admit him though he declined. Mr Ginn said that he had vague and fleeting thoughts of suicide and self-harm so the nurse decided that Mr Ginn did not present an immediate, heightened risk. Mr Ginn also said that he needed a Continuous Positive Airway Pressure machine (CPAP – used to treat obstructive sleep apnoea) and the nurse arranged for the prison to accept this. The nurse also arranged for Mr Ginn's prescriptions to continue, including a prescription for sertraline (an antidepressant).
38. On the same day, an officer completed a Cell Sharing Risk Assessment for Mr Ginn and noted that the PER said that he presented a suicide and self-harm risk. An officer reviewed and agreed with the assessment. There was no record that both officers considered starting Prison Service suicide and self-harm monitoring (known as ACCT).
39. An officer also completed a Risk of Self-Harm or Suicide form for Mr Ginn and ticked yes to the questions, "Has the individual made any statement or recent act of self-harm?", "Any known history of self-harm?", "First time in prison?" and "Has the individual received a longer sentence than they expected?". The officer noted that Mr Ginn had cut his left wrist on 1 September 2018, that he said he had occasionally hurt himself and that he said he had expected a suspended sentence. There was no record that the officer considered starting an ACCT, despite the form saying, "ensure that you have considered opening an ACCT plan if you have ticked 'yes' in any of the boxes".
40. At 10.35am on 6 November, a nurse saw Mr Ginn for a secondary health assessment. Mr Ginn said that he had thoughts of suicide and he answered yes to five questions about his mental health. The nurse referred Mr Ginn for a mental health assessment and placed him on an ACCT. Once the ACCT was opened, Mr Ginn listed his wife as his next of kin.
41. At 2.20pm, an officer completed an ACCT assessment interview with Mr Ginn, who said that he had "a suicidal ideology", had recently cut his arm and that he had attempted suicide numerous times. Mr Ginn said that that he would not tell

staff if he hurt himself or tried to take his own life. Mr Ginn said that he was not sleeping well, due to not having his CPAP machine, and that he was suffering with depression.

42. At 2.30pm, a SO held the first ACCT case review with Mr Ginn, an officer, the primary care mental health lead and the wellbeing coordinator. The SO noted that Mr Ginn contributed well but seemed low in mood. Mr Ginn said it was his first time in prison and he was shocked and ill-prepared. Mr Ginn said that he was fed up with life and had thought about ending his life, though he had no immediate plan. The SO decided that Mr Ginn presented a raised risk of suicide and self-harm (on a scale of low, raised and high) and that staff should observe him every hour. The SO scheduled the next ACCT case review for 12 November.
43. The SO also completed Mr Ginn's caremap (designed to identify the main areas of concern and the actions required to reduce risk) and added two actions. The SO decided that Mr Ginn needed to see a prison doctor to discuss his medication and to see the mental health team about his depression.
44. Following the ACCT case review, the wellbeing coordinator added extra information to Mr Ginn's electronic medical record. The wellbeing coordinator noted that Mr Ginn actively believed that he should kill himself, as it was part of his "belief system". Mr Ginn said that as he was not expecting to be in prison, he had not brought his CPAP machine or arranged for someone to look after his cat. He also said that he was under the care of Tower Hamlets' community mental health team.
45. At 3.33pm, Mr Ginn's sister telephoned the prison and spoke to a residential governor. She said that Mr Ginn was suicidal and that before he went to prison, he had tried to buy a gun to take his life. The residential governor assured Mr Ginn's sister that he had been seen by healthcare staff as part of the induction process.
46. On 7 November, staff at a health and wellbeing referral meeting, involving the primary care mental health lead, the wellbeing coordinator, the mental health team manager and a senior mental health practitioner discussed Mr Ginn. The attendees noted that the community mental health team had diagnosed Mr Ginn with a chronic depressive disorder, which was not acute in nature, and they planned to manage him in primary care with a psychiatric follow up in February 2019. The mental health team manager discussed Mr Ginn with psychiatry staff.
47. On the same day, an unidentified member of staff completed an Intelligence Report that alleged that two prisoners had stolen a vape and other items from Mr Ginn's shared cell. The member of staff checked the alleged thieves' cell but did not find any extra vapes.
48. The following day, a prison GP saw Mr Ginn, who said that he felt hopeless at times. Mr Ginn felt he was being bullied by other prisoners and that he would be better off dead, though he did not have any active plans to take his own life. He also said that he would be non-compliant with his medication at times out of spite to himself. The prison GP noted that Mr Ginn was smiling and jovial and did not seem guarded, distracted or experiencing delusional thoughts. The prison GP

wanted the equalities officer to review Mr Ginn and he completed a referral on 13 November.

49. On the same day, the Security Department sent a Security Information Notification to the residential managers, which contained 16 intelligence summaries including the allegation that Mr Ginn and his cellmate had had items stolen from them. Following this, there is no other record that Mr Ginn alleged that he was being bullied.
50. On 12 November, a SO held the second ACCT case review with Mr Ginn and two case workers for Phoenix Futures (a drug and alcohol psychosocial service). The SO noted that Mr Ginn gave good eye contact and said that he had no thoughts of suicide. Mr Ginn said that he had not abused drugs or alcohol since 1986, though he had used “sleepers” in an overdose. Mr Ginn said he had suicidal thoughts when he arrived at Pentonville as he was in the “wrong place”. He also said that he did not have any family visits planned, and that he did not see his family when he was in the community. The SO wrote that Mr Ginn was aware of the support available to him and did not add any actions to the caremap. The SO decided that Mr Ginn presented a low risk of suicide and self-harm and that staff should observe him every two hours. The SO scheduled the next ACCT case review for 19 November.
51. On 17 November, Mr Ginn refused to collect his medication, as he wanted a weekly supply of his diabetes medication. A nurse arranged for this to happen though Mr Ginn still needed to collect his other prescriptions on a daily basis. The nurse also supplied Mr Ginn with his CPAP machine.
52. On 19 November, a SO held the third ACCT case review with Mr Ginn. The mental health team manager provided a verbal report. The SO told Mr Ginn that the mental health team were going to review him on 26 November. Mr Ginn explained why he had not taken his medication and said that he was depressed about his finances. Mr Ginn said that he felt the same about hurting himself. The SO decided that Mr Ginn’s level of risk and the level of observations did not need to be changed. The SO scheduled the next ACCT case review for 26 November.
53. On the same day, an equalities officer saw Mr Ginn and arranged for him to move cells so he could use the lower bunk. On 20 November, Mr Ginn was moved to a double cell which he occupied on his own.
54. On the same day, a senior mental health practitioner saw Mr Ginn for a primary care mental health assessment. When asked what support he wanted, Mr Ginn said that he wanted help to die, in the form of morphine. Mr Ginn told her that he had plans to kill himself but would not tell her or she would stop his plans. He admitted that he had contemplated telling other prisoners about his offence so they would “shank” (stab) him. He said that he received some support from his youngest daughter and a female friend. She completed a patient health questionnaire and a generalised anxiety disorder score with Mr Ginn, which showed that he had severe depression and severe anxiety disorder. She planned for Mr Ginn to continue with his prescribed medication and for the primary care mental health team to review him within two weeks.

55. At 3.00am on 26 November, an operational support grade (OSG), checked on Mr Ginn, who said that he felt isolated and did not want to go back to living in the community. Mr Ginn said that he had not told his family about his offence but assumed that they knew about it as he had appeared in the media. He said that this made him feel suicidal. The OSG advised Mr Ginn to write to his daughter to ease some of his tensions.
56. Later that same day, a SO held the fourth ACCT case review with Mr Ginn and two Phoenix Futures case workers. The SO noted that Mr Ginn gave good eye contact, though he was worried about his housing benefit being stopped. Mr Ginn confirmed he thought about taking his life because he had heard about "what's awaiting him on the out". The SO asked whether he had a specific plan but Mr Ginn refused to say, though he did say there was nothing in his cell to hurt himself with. The SO wrote that Mr Ginn was aware of the support available to him. The SO decided that Mr Ginn's level of risk and the level of observations did not need to be changed. The SO scheduled the next ACCT case review for 5 December.
57. The SO added an action to Mr Ginn's caremap that Mr Ginn needed to make an application to resettlement to sort out his stopped housing benefit.
58. A Phoenix Futures case worker told the investigator that Mr Ginn had said that the only way the staff could help him was by giving him rope and that he still wanted to kill himself.
59. Later that same day, a psychiatrist saw Mr Ginn for a mental health assessment. During the assessment, Mr Ginn joked about his previous episodes of self-harm and said that he would be better off being stabbed by another prisoner. Mr Ginn said that his daughters and a female friend were protective factors and that he was scared of dying. The psychiatrist noted that Mr Ginn made strong references to despair and feelings of loneliness, and diagnosed him with an adjustment disorder (a stress-related condition). He decided to increase Mr Ginn's sertraline prescription, referred him for cognitive behaviour therapy and planned to see Mr Ginn before the Christmas holidays.
60. At 7.17am on 28 November, the Head of Security checked on Mr Ginn's ACCT document. She noted there were too few conversations or interactions with him and that healthcare staff needed to attend the case reviews.
61. At 3.30pm, an officer recorded on Mr Ginn's ACCT observation record that he was "in a very bad way" and "incredibly withdrawn". Mr Ginn said that he had nothing to live for, would be better off dead and that a female friend had written to him to accuse him of lying about his crimes. An officer made a similar entry in the F Wing observation book but did not ask for an immediate ACCT case review.
62. Between 8.25pm and 11.06pm, an officer and an OSG checked on Mr Ginn three times and found him watching television.

## **29 November 2018**

63. At approximately 1.00am on 29 November, the OSG started ACCT checks on F Wing. She checked six prisoners before she arrived at Mr Ginn's cell. She looked through the observation panel and saw Mr Ginn had a ligature tied around

his neck. She said that she did not call a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) because she panicked, although she called for help from another OSG. The second OSG quickly arrived and, at 1.08am, called a code blue. They did not enter the cell.

64. A Custodial Manager (CM) and three prison officers quickly responded to the code blue emergency. They entered the cell and untied the ligature, which was made from bedding and was too thick to cut. They moved Mr Ginn out of the cell and immediately started cardiopulmonary resuscitation (CPR). Two nurses then arrived and they tried to insert an airway but found that Mr Ginn's mouth and neck were stiff. They attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.
65. At 1.10am, an officer called for an ambulance and paramedics reached Mr Ginn at 1.24am. They inserted an airway and gave him adrenaline and sodium chloride. The paramedics were unable to resuscitate Mr Ginn and, at 2.10am, an advanced paramedic declared that he had died.

### **Contact with Mr Ginn's family**

66. Following Mr Ginn's death, the prison appointed an administrative officer as the family liaison officer (FLO). At approximately 5.00am, the Metropolitan Police visited the home address of Mr Ginn's sister and broke the news of his death.
67. At 11.10am, the FLO and Governor visited the home address of Mr Ginn's sister and offered their condolences and support. The FLO continued to support Mr Ginn's sister until his funeral, which was held on 2 January 2019. The prison paid for the costs of the funeral in line with national instructions.

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

68. After Mr Ginn's death, a CM 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.
69. The prison posted notices informing other prisoners of Ginn'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 Ginn's death.

### **Post-mortem report**

70. The post-mortem examination found that Mr Ginn's death was caused by partial suspension. The pathologist considered that Mr Ginn would have rapidly become unconscious, within eight seconds, after critical compression of his neck.
71. The toxicology examination revealed prescribed medication within therapeutic ranges, which had no impact on Mr Ginn's death. No illicit substances were found in his blood sample.

# Findings

## Assessment of Mr Ginn's risk of suicide and self-harm

72. Prison Service Instruction (PSI) 64/2011 sets out the processes that should be followed when an ACCT has been opened. This includes that the case review team must review the level of risk that a prisoner presents taking into account all available information, that the ACCT case review team must be multidisciplinary and relevant to the review, and that staff must follow the planned frequency of observations. It also lists triggers that may increase the risk of self-harm or suicide, which includes family and relationship breakdowns, and that consideration must be given for involving a prisoner's family where beneficial.
73. Guidance on these processes is also contained in the ACCT documentation which states that a prisoner should be regarded as a raised risk of suicide and self-harm when they present frequent but fleeting suicidal ideas, there is evidence of mental illness and there have been previous suicide attempts.
74. Throughout Mr Ginn's time at Pentonville, he regularly described his suicidal thoughts and he suggested wanting rope, morphine or to be killed by another prisoner to bring about his death. He also described being fed up with life and that he had nothing to live for. When comparing these comments and his previous suicide attempts while in the community against the guidance in the ACCT document, we consider that the ACCT case review attendees should have put Mr Ginn's risk at raised rather than low. While we cannot be sure what impact this would have had, it is likely that it would have resulted in more regular observations and a more immediate mental health review.
75. Mr Ginn had been on an ACCT for 23 days yet prison staff only held four ACCT case reviews during that time. There was a gap of six days between the first and second case reviews despite a SO having decided that Mr Ginn presented a raised risk. After the second case review, the gap between reviews extended to seven days. We consider that these gaps placed Mr Ginn at a greater risk of suicide as there was less opportunity to find out about his concerns, offer him support and take actions to remove or minimise his risks.
76. During the first two ACCT case reviews, staff recognised that Mr Ginn needed to see the mental health team about his depression and Mr Ginn said that he had not abused alcohol or drugs since 1986. Despite this, mental health staff only attended or contributed to the first and third case reviews. We are concerned that the prison sent Phoenix Futures staff to Mr Ginn's second and fourth case reviews and that their expertise was not relevant to Mr Ginn's situation.
77. We are also concerned that staff regularly failed to follow the level of observations set by during the ACCT case reviews. Between 6 and 12 November, a SO planned for observations every hour yet there were 36 instances when staff did not review Mr Ginn within an hour, with the longest gap being two hours and 30 minutes. From 12 November, when a SO set observations at every two hours, there were 33 instances when staff did not review Mr Ginn within two hours, with the longest gap being five hours and 30 minutes.

78. We are also concerned that many observations took place exactly an hour or two after the last observation and not at unpredictable times.
79. During his assessments with the senior mental health practitioner and a prison GP, Mr Ginn said that his daughters and a female friend were protective factors yet this information was not recorded in his ACCT. As a result, staff did not appreciate that the breakdown of his relationship with his friend was a potential trigger for suicide and self-harm. This meant that an officer was not fully aware of the significance of Mr Ginn's statement on 28 November that a friend had accused him of lying about his offences, and that this did not prompt an immediate case review. Furthermore, as this information was not recorded in his ACCT, there is no record that anyone considered inviting one of his daughters to an ACCT case review. We make the following recommendation:

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

- **consider all risk factors, including suicidal statements, apparent planning and previous suicide attempts, when assessing a prisoner's risk;**
- **schedule case reviews at appropriate intervals, in line with the prisoner's level of risk;**
- **hold multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care;**
- **adhere to the frequency of observations set out in the ACCT document and ensure that observations take place at unpredictable times;**
- **record details of protective factors and potential triggers in the ACCT document; and**
- **involve the prisoner's family when that would be appropriate.**

## Reception

80. PSI 07/2015, *Early Days in Custody*, sets out the processes that should be followed when a prisoner arrives at a prison. This includes that all available documentation should be reviewed and the prisoner should be interviewed to assess their risk of self-harm, with an ACCT opened where appropriate.
81. When Mr Ginn arrived at Pentonville from court, he arrived with a Person Escort Record that recorded he was at risk of suicide and self-harm, though it did not give details. An officer and a nurse also interviewed Mr Ginn and his responses demonstrated that he was at risk as shown by the four 'yes' answers on the Risk of Self-Harm or Suicide Form and his comment about having fleeting suicidal thoughts comment.
82. Despite having reviewed various documents and interviewed Mr Ginn, neither the officer nor the nurse opened an ACCT. They also did not explicitly record their reasons for not doing so. This is particularly concerning since the Risk of Self-Harm or Suicide form contains two warnings that an ACCT should be considered if any 'yes' answers have been given. Although starting ACCT procedures at an

earlier time would not have changed the outcome for Mr Ginn, it could be critical in other cases. We make the following recommendation:

**The Governor and the Head of Healthcare should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with documents detailing a risk of suicide and self-harm, they should clearly record the reasons.**

### Mental health

83. Mr Ginn had a history of chronic depression, which healthcare staff treated with sertraline. After arriving at Pentonville, and having been placed on an ACCT, Mr Ginn was referred to the primary care mental health team and was seen by the senior mental health practitioner and a prison GP. The prison GP assessment led him to diagnose Mr Ginn with an adjustment disorder.
84. The clinical reviewer considered that, at this point, Mr Ginn's level of risk had increased and his mental health had deteriorated to an extent that he should have been referred to the mental health inreach team. This would have allowed Mr Ginn to receive continuing oversight from appropriate clinicians. However, there is no record that anyone made or contemplated making a referral to the mental health inreach team. In failing to do so, the clinical reviewer considered that Mr Ginn's mental health care was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

**The Head of Healthcare should ensure that there is effective and clear liaison between the primary care mental health team and the mental health inreach team, which allows a prisoner's suitability for each mental health team to be promptly reassessed.**

### Emergency response

85. PSI 03/2013, *Medical Emergency Response Codes*, contains a mandatory instruction that staff must call a code blue if a prisoner is not breathing or is unconscious and that on hearing the code blue, control room staff must call an ambulance immediately.
86. PSI 24/2011, *Management and Security of Nights*, states that staff have a duty of care to prisoners, to themselves, and to other staff, and that preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life then a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.
87. When the OSG found Mr Ginn, she panicked and called for help from another OSG rather than calling a code blue emergency. Although the second OSG responded quickly and called the code blue, we are concerned that failing to use the correct emergency code may result in unnecessary delays in the future.
88. We are also concerned that there was a two-minute delay before the control room called an ambulance.

89. After calling the code blue emergency, neither OSG's entered Mr Ginn cell. While we appreciate the distress of seeing a prisoner in such circumstances and that officers must have regard for their own safety when deciding whether to enter a cell or not, we do not understand why both OSG's concluded that it was not safe to enter Mr Ginn's cell given what they had seen. By failing to follow PSI 24/2011 and immediately enter Mr Ginn's cell, there was an unnecessary delay in treating him. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:**

- **staff enter cells as quickly as possible in a life-threatening situation;**
- **staff radio an appropriate emergency code; and**
- **control room staff call an ambulance as soon as an emergency code is called.**

### **Family liaison**

90. PSI 64/2011 sets out the guidance and mandatory actions for prison staff to follow for identifying a prisoner's next of kin. This includes that information about the next of kin must be kept up to date and that the family liaison officer must visit the next of kin to break the news of the death in person whenever possible.
91. When Mr Ginn arrived at Pentonville, he did not list anyone as his next of kin. However, when a nurse placed Mr Ginn on an ACCT on 6 November, he added his wife as his next of kin. This information was ignored when Mr Ginn died as his sister was the first person told of his death. We are concerned that the prison disregarded Mr Ginn's choice about his next of kin and did not follow the instructions in PSI 64/2011 about keeping his next of kin details up to date.
92. The FLO told the investigator that the Metropolitan Police had told Mr Ginn's sister of his death by accident and that he had only asked the police to tell him that it was safe to visit that address. While we appreciate that this happened by accident, the prison should ensure that, in the future, a family liaison officer breaks the news of the death to a next of kin in person. If the police are asked for any assistance, the prison should ensure that the request is fully understood to avoid any mistakes. We make the following recommendation:

**The Governor should ensure, in line with PSI 64/2011, that:**

- **when a prisoner changes their next of kin, staff update the prisoner's NOMIS prison record promptly; and**
- **a family liaison officer breaks the news of a death to a next of kin in person as soon as possible.**

### **Staff support**

93. PSI 64/2011 sets out the actions that should be taken following a death in custody. This includes that all staff involved in a death, including healthcare staff,

should be invited to a hot debrief; that it can be useful to record who attended the debrief; and that staff may require support at any time.

94. Following Mr Ginn's death, the OSG remained working on F Wing despite having found him and a CM led the hot debrief despite having been actively involved in the resuscitation attempt. We consider that this was inappropriate because of their significant involvement, and that senior managers should have moved the OSG to another wing for the rest of her shift and should have led the debrief, allowing the CM to receive rather than offer support. We are concerned that both episodes displayed a lack of care and support.
95. We are also disappointed that no one recorded who attended the hot debrief so we cannot be sure that all the prison and healthcare staff involved in the resuscitation attempt were appropriately supported.
96. We make the following recommendation:

**The Governor should ensure that, following a death in custody, staff receive adequate support and that a manager, not involved in the death, leads a hot debrief and records who attends.**

### **Bullying allegation**

97. Shortly after his arrival at Pentonville, Mr Ginn alleged that other prisoners had stolen items from his cell and he told a prison GP that he felt he was being bullied. After making Mr Ginn made this allegation, the Security Department passed information to the residential managers to keep an eye on Mr Ginn and the alleged perpetrators. Following this, there is no record that Mr Ginn made any other comment about being bullied and we are satisfied that the prison appropriately dealt with the allegation.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations