

**Investigation into the death of a man whilst in the
custody of HMP Pentonville in February 2011,**

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

September 2011

This is a report into the death of the man in February 2011, whilst he was in the custody of HMP Pentonville. The man was found hanging in his cell, having been in prison less than a month.

I offer my sincere condolences to his family and friends for their loss. My senior family liaison officer contacted the man's brother to tell him about the investigation and give him the opportunity to raise any issues about the care his brother received in custody.

The investigation was carried out by one of my investigators. Both he and I would like to thank the governor and his staff, for their co-operation during the course of our enquiries.

I also thank Islington Primary Care Trust for appointing the clinical reviewer to review the man's clinical care.

The man chose to withhold his change of name, previous medical and custodial history and gave no indication to staff at Pentonville that he was troubled in any way. Staff believed that he was in prison for the first time and had no significant personal or health issues.

The findings of the clinical review play an important part in my report into relation to the man's physical and mental health assessment. The review shows that he received standard of care which was equitable to that which he could have expected in the community. I make no recommendations and I commend the speed and professionalism of the staff involved in the emergency response when the man was found hanging. I am concerned that information which linked the man to his previous name was not effectively shared between the police, court and prison. I therefore will share this report with the Commissioner of the Metropolitan Police.

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

Thea Walton
Acting Deputy Ombudsman
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SUMMARY

1. The man was born in October 1969. The man changed his name by deed poll. Under his former name the man had previously served custodial sentences.
2. In January 2011, the man appeared at Romford Magistrates' Court and was remanded into the custody of HMP Pentonville until his next court appearance, at Basildon Crown Court on 4 March. On arrival at the prison, the man told healthcare staff that this was his first time in custody, that he took no medication, did not drink alcohol, had no history of mental illness and had no thoughts of self harm.
3. The man chose to withhold his change of name, previous medical and custodial history, which meant that a true picture of his wellbeing and status was not obtained.
4. During his time at Pentonville the man had no further contact with healthcare staff and discipline staff did not have any concerns about him whilst he was on the wing.
5. The man was found hanging in his cell and emergency medical assistance was called. Healthcare staff began cardio pulmonary resuscitation (CPR) until the paramedics arrived and took over his care. After consulting with the paramedics a prison doctor confirmed that the man had died at.
6. It is the clinical reviewer's opinion that the care and medical assessment the man received at Pentonville was equitable to that which he could have expected to receive in the community.
7. I make no recommendations but do recognise the speed and professionalism of the staff who responded to the emergency situation. I am concerned that key information which linked the man to his previous name and showed a record of convictions, previous custody and any known risk factors was not effectively shared between the police, court and prison.

THE INVESTIGATION PROCESS

8. The investigation was opened on 4 February 2011 when my investigator issued notices announcing the investigation to staff and prisoners. No one came forward as a result.
9. The investigator visited HMP Pentonville on 9 February. He was given copies of all documentation relating to the man and saw where he lived. The investigator returned to Pentonville on 16 March, 29 March and 2 June 2011 and interviewed six members of staff. All interviews were recorded and transcripts are annexed to this report. The investigator provided written feedback to the Governor on 2 June 2011.
10. Islington Primary Care Trust asked a clinical reviewer to review the man's clinical care. My investigator and the clinical reviewer jointly discussed aspects of the man's treatment with healthcare staff at Pentonville. I am grateful to the clinical reviewer for her detailed and timely report.
11. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.
12. My senior family liaison officer contacted the man's brother to inform him about the investigation and to invite him and his parents to ask any questions or raise any concerns about the care the man received in prison. My senior family liaison officer and investigator visited the man's family on 19 May and they raised the following issues:

How much information, if any, was transferred from the Police authorities to the Prison Service upon the man's remand to Pentonville.

- Whether the man's letters had been monitored, as a letter he had sent to his friend on 26 January 2011 stated '*if anything should happen to me while I'm in here, could you ensure that any money I have goes to the 5035 locomotive society*'. The family believe this was a clear indication that something was not right and would like to know if this information had been identified by the prison.
- The family believe that the man was refused a phone card and had not been allowed a pair of shoes, with laces, and was being denied his basic privileges.
- The family were dissatisfied with the treatment they received from the Prison Family Liaison Officer at Pentonville which they described as insensitive, uncaring and unprofessional and had caused the family additional distress.

HMP PENTONVILLE

13. Pentonville was built over 150 years ago, and serves the London courts. It has an operational capacity of 1,250 prisoners.
14. A manager heads Pentonville's healthcare department, with Whittington Health; Camden & Islington NHS Foundation Trust; and Barnet, Enfield and Haringey NHS Mental Health Trust providing health services. Services provided include substance misuse, mental health services, psychiatric care and primary care services.
15. The healthcare centre is a new purpose-built building offering both inpatient beds and a day care facility for prisoners with mental health problems. There are primary care facilities on the wings, including a consulting and dispensary area. Healthcare staff are available 24 hours a day. Doctors, mental health and nurse-led clinics are available, as well as a range of more specialised services.
16. The Chief Inspector of prisons led the most recent unannounced inspection of Pentonville from 24 February 2011 to March 2011. The inspection report, published in June 2011, said in summary:

“Pentonville is an iconic prison, but not always for the right reasons: its four central wings are over a hundred and fifty years old, it has a large and transient population drawn from some of London's poorest boroughs, and its prisoners have amongst the highest incidence of mental illhealth and substance abuse of any local prison in the country. Despite these almost insuperable challenges, this unannounced follow-up inspection found that Pentonville was making some progress but inevitably there was much more to do.

“Reception remained immensely busy and staff had little time to address all the immediate issues presented by prisoners. Similar pressures on first night and induction arrangements meant that much work remained to be done to ensure the safety of prisoners in their most vulnerable early days in custody. The atmosphere in the prison was generally calm but violence reduction and anti-bullying systems were weak. Tragically, there had been four apparently self-inflicted deaths since the last inspection and, while some aspects of the care for those at risk of self-harm were good, other areas were underdeveloped.

“Many men arriving at Pentonville were dependent on drugs and/or alcohol and treatment arrangements had improved with the introduction of the integrated drug treatment system. There had also been some success, working with the police, to reduce the flow of illicit drugs into the prison. Security was mostly proportionate and use of force was not excessive.

“Staff-prisoner relationships appeared reasonable, but were not supported by an effective personal officer scheme. The environment was generally clean but some accommodation was overcrowded, with unscreened toilets and poor showering facilities. Race issues were well managed but some other areas of diversity, particularly services for foreign nationals, were underdeveloped. Faith provision was comprehensive. There was an impressive health care centre and most services were good.

“Time out of cell varied, but was reasonable for those with activities to attend. Despite some ambitious plans, there was still too little activity to occupy all prisoners and many prisoners remained unemployed. Opportunities to access education had expanded significantly but too few prisoners achieved qualifications. Access to the library had improved and more prisoners were now able to take part in PE.”

17. An Independent Monitoring Board (IMB) is appointed to each prison by the Secretary of State for Justice. Its members are independent of the Prison Service and the prison’s management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and areas of concern.
18. The latest IMB report covered the period from 1 April 2009 to 31 March 2010. It noted that:

“The new Health Service provider, a consortium led by Islington PCT (Primary Care Trust), started on 1 April 2009. For various reasons, they have struggled to fill a significant number of vacancies. The post of lead GP was vacant for 10 months. Agency nurses were hampered by having no keys.”
19. This is the 14 self inflicted death at Pentonville that my office has investigated since becoming responsible for investigating all deaths in prison custody in April 2004. There are no similarities between the findings of previous deaths and the man’s death.

KEY EVENTS

20. The man was born in October 1969. He changed his birth name by deed poll approximately two years before his death. Under his former name the man had previously served custodial sentences. The man was single and lived in Essex. Prior to entering prison the man was employed as a Maintenance Shift Manager by a major UK company.
21. On 6 January 2011 the man appeared at Romford Magistrates Court and was remanded into custody at HMP Pentonville on a number of specified charges. The man was scheduled next to appear at Basildon Crown Court on 4 March.
22. The documentation that accompanied the man from the court to Pentonville included the Person Escort Form (PER), Warrant of sending to Crown Court for trial, and the MG4 Form Charge documents (completed by the court, police and custodial transfer staff).
23. The PER detailed the time the man arrived at Romford Magistrates Court, the number of cell checks, how often the man was offered and accepted food and drink, that the man gave his property to his legal representative and the time the left the court for Pentonville. There is room on the PER to record details of potential risk such as self harm, at risk of abuse, drug or alcohol issues. The man was not identified as being at risk, nor linked to any previous custodial sentences in a former name.
24. On the man's arrival at Pentonville the officer completed the Security Collators Initial Assessment. This is a security form that the officer completes to confirm the documentation that arrived with the man from court. The officer noted that there was no pre-sentence report, no previous conviction history or previous prison documentation.
25. Later that evening the man had a reception health screen. The man told the nurse that he did not take any medication and was not registered with a community doctor. He said that this was his first time in custody and he had not used drugs and did not drink. The nurse recorded that the man had no mental health issues and had no thoughts of harming himself. His blood pressure was recorded as 143/90. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.). The nurse noted that the man was on remand and his next court date was 4 March.
26. The second officer who saw the man completed a cell sharing risk assessment (CSRA) (the risk assessment considers the risk posed to others by the individual) and assessed that the risk was low and the

man could be allocated to a double cell. The man spent his first night in custody in cell A2-023.

27. The next morning a second nurse saw the man for a second health screen. The nurse recorded his blood pressure as 132/88, his weight as 85kg (13 stone 4lb) and his height as 177.8cm (5' 9"). The man told the nurse that this was his first time in custody, he smoked two cigars a day, had not used drugs, did not drink alcohol and enjoyed light exercise. He said that he did not have any family medical history. The nurse recorded that the man was not on any medication, had no physical health problems, had no mental health problems, had no thoughts of self harm and was fit to use the gym. The man did not give his consent for any community doctor records to be obtained and declined a Chlamydia (sexually transmitted disease) screening test. That evening the man was allocated to cell A4-037. This was his cell for the remainder of his time at Pentonville.
28. In the days that followed that followed the man seemed to adapt to life in prison and wing staff recalled him as being quiet, reserved, polite, and someone who opted to remain in his cell most of the time during association periods. At interview a third officer said:

“The interactions I had with him he didn’t come across that he was upset or depressed. I saw him as a mature individual on my landing. He wasn’t one of these that I would have expected to be up and down and running around on the wing and he sort of very much kept himself to himself. He used to go down and collect meals, had his showers, he’d ask for toiletries but most of his time he kept himself to himself and stayed in his cell. I wasn’t concerned about that because a lot of lads, the more mature prisoners do.”
29. The third officer who saw the man also added that there were no apparent problems between the man and his cellmate, that the man did not complain he had problems with his phone card and he never gave any indication that he was frustrated or depressed.
30. On the morning of 15 January the man had a visit from friends. The man’s family told my investigator that he wrote a letter to his friends on 26 January in which he said ‘if anything should happen to me while I’m in here, could you ensure that any money I have goes to the 5035 locomotive society’. His family believe that this is a clear indication that something was wrong. The man’s outgoing mail would not have been read and he did not raise any concerns with staff.
31. On 27 January, the man was due to have a visit from his legal representatives however they did not attend. The man did not make any telephone calls. The man was authorised to make telephone calls to two separate numbers he provided for friends, and his legal representative.

32. The man's cellmate was taken to court on the morning of 1 February and did not return to Pentonville as he was sent to HMP Brixton. The man lived in the cell on his own after the cellmate's departure.
33. The investigator received a letter from the cellmate in which he wrote that he had shared a cell with the man for approximately three weeks. He wrote that the man was a nice man who helped him with his English. They used to watch television together, talk and share tobacco. The cellmate gave no indication that the man was worried or depressed.
34. All prisoners at Pentonville are given breakfast packs the previous evening. On the evening of 2 February a roll check of A wing was conducted at 7.55pm, after all prisoners had been locked in their cells for the night. The check on prisoners is done by an officer looking through the observation hatch of the cell door to see the prisoners are present. This check is not designed as a check on well being, it is a security measure to check that all prisoners are accounted for. Any concerns have to be reported. There were no concerns recorded for the man at this check.
35. During the night the prison is in night patrol state. All prisoners remain in their cells and there is a restricted number of staff on duty. Each cell has an alarm bell that a prisoner can press to summon assistance from a member of staff. The timing of each call made on the cell bells, and the time of the response, is logged, and the records showed that the man did not use his cell bell at any time from the evening of 2 February through to the morning of 3 February.

Events in February

36. There was a second roll check of the prisoners on A Wing at 5.30am and no concerns were reported. When the night staff handed over to the day staff there was a further roll check undertaken and this was conducted at 6.40am and again there were no concerns raised.
37. At Pentonville, prisoners who require medications, those attending court and those attending workshops or educational courses are unlocked first. Once this has happened, the remainder of the prisoners are unlocked for association (time allowed out of cell to mix with other prisoners on the wing), usually around 10.00am.
38. At 10.05am, the first officer on the scene came to the man's cell to unlock the door but noticed that the observation hatch had been covered from the inside. The officer opened the cell door and saw the man hanging from the cell window bars using bedding as a ligature, and had a pillow case over his head. The first officer on the scene shouted for assistance and the second officer on the scene immediately responded, entered the cell and cut the ligature with a ligature knife (officers are provided with a specially designed knife to

cut ligatures) and put the man in the recovery position. The first officer on the scene used the radio to contact the communications room to raise the alarm for urgent medical assistance for a Level One emergency (this denotes that someone has been found hanging).

39. The Level One call was transmitted at 10.07am and very quickly the first officer on the scene and the first nurse on the scene, second nurse on the scene and a third nurse were at the man's side and had started cardiopulmonary resuscitation (CPR), using an airway bag and an automated external defibrillator (AED) (which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary).
40. The 999 call was made at 10.08am and the first paramedic on a motorbike arrived at 10.14am, a second in a car arrived at 10.16am and an ambulance arrived at 10.18am. The paramedics took over and continued the CPR from the nurses. At 10.45am, the prison doctor arrived and, after consulting with the paramedics, pronounced that the man had died.
41. Following the man's death prisoners were offered support from the chaplaincy, IMB or the Samaritans. A hot debrief was held for all staff involved in the emergency response and support was made available from the local care team and the national Employee Support Service. (Hot debriefs should be led by a senior member of prison staff and are intended to offer staff involved the opportunity to discuss the incident. The purpose is to offer reassurance, information and support.)
42. As the man had not given any details of his next of kin on arrival at Pentonville the police were asked if they were aware of any next of kin. The police contacted the prison later that afternoon to give Pentonville the contact details of the man's brother. The prison family liaison officer contacted the man's brother to make arrangements to visit him, however at that time he was travelling to Birmingham.
43. The prison family liaison officer contacted HMP Birmingham to ask for their cooperation in breaking the news to the man's brother. The governor at HMP Birmingham agreed to break the news to the man's brother and saw him that evening at the address where he was staying in Birmingham.
44. In the days that followed Pentonville and offered support and financial assistance towards the funeral expenses. However, the family were dissatisfied with the service they received and I consider this further in the issues section of this report.
45. The prison family liaison officer was also aware from prison documentation that the man was due to receive a visit from the man's friends on Saturday 5 February. He contacted the man's friend by telephone to inform them that the man had died.

ISSUES

Clinical care

46. The clinical reviewer, has carefully considered the overall clinical care given to the man and concludes:

“The man received appropriate health screenings on his first and second day after arriving into custody. It was noted that he did not give consent for his GP records to be obtained and that he did not give his GP details in reception. Due to his good physical and mental health there was no cause for concern raised. He denied having any mental health problems or substance misuse problems and neither were evident through the assessments and observation that were undertaken by the nurses that he saw.”

47. From the information given by the man’s family the investigator was able to establish that the man had registered with a doctor’s practice in Barking, Essex and attended the practice for a new patient check on 25 November 2010. This was the man’s only attendance at the surgery and he was not given any medication.

48. In her report the clinical reviewer concludes:

In my opinion the care that the man received was both appropriate and equitable to the care he would have received in the community. His initial assessments and well-man checks gave no indication to any mental health problems or intention to harm himself in any way. There was nothing that the man declared or displayed in any symptoms that would have led to the healthcare staff being concerned that the man would attempt to take his own life. I therefore have no concerns about the care he received, or have any recommendations for the prison service or NHS Islington.

49. I am satisfied that the medical assessment and care that the man received whilst at Pentonville was equitable to that which would have been available to him in the community.

Emergency response

50. The staff response to the man’s need for assistance was swift and professional. The clinical review makes the following comments regarding the emergency response:

“On the morning of 3 February 2011, three nurses responded to a medical life threatening emergency radio call. The first nurse to arrive.....

“With the assistance of the second nurse on the scene and followed by the third nurse on the scene, CPR was commenced. The

automated external defibrillator was attached and intravenous access to his right arm was gained. Due to the man not having any cardiac rhythm there was no instructions to shock him during the CPR.

“When the London Ambulance Service arrived they assisted the resuscitation process, however after five cycles of resuscitation which included the use of Adrenaline a team decision was made to terminate the resuscitation and death was certified by the prison doctor.”

51. The clinical reviewer and I recognise and commend the actions and professionalism of all the staff who responded the emergency situation.

Family liaison

52. I am pleased to note that Pentonville contacted HMP Birmingham to ask their family liaison officer to visit the man’s next of kin. As Birmingham was closer to where the man’s brother was staying at that time, it meant that the news of his death was given face to face, by an appropriately trained member of Prison Service staff. Pentonville followed the guidance on this matter set out in PSO 2710 ‘Follow up to deaths in custody’, and I am pleased that Birmingham readily agreed.
53. The man’s family told my investigator that the prison family liaison officer from Birmingham was “excellent” however they described the subsequent contacts from the family liaison officer from Pentonville as “insensitive, uncaring and unprofessional” and this had caused the family additional distress at the time of their loss. My investigator interviewed the prison family liaison officer, who said that he believed that he had treated the family with dignity and respect.
54. The man’s family told my investigator that after five days of not hearing from the prison liaison officer, they then contacted him to find out what was happening. The prison liaison officer said that, as the man had died on Thursday 3 February, he had planned to call the family the following Monday to allow them time to come to terms with the news of their loss and have all the relevant information from the Coroner’s Office to pass on to them.
55. The family said that they were not provided with the directions to the mortuary, nor met at reception on the day that they identified the man’s body. The prison liaison officer spoke to, and received text messages from the man’s brother regarding attending the mortuary and at no time was he made aware that the family had any problems in getting to the mortuary. The family were collected from reception and taken to the mortuary when they arrived.
56. The family said that there was a delay in being allowed to visit the prison to see the man’s cell until after the funeral had taken place. The

man's brother had been told by the prison liaison officer that the prison had to wait for authorisation from the police and Corner's Office before the cell could be opened. The authorisation was received on 18 February and the prison liaison officer contacted the man's brother to make arrangements to visit the prison the following week. The man's brother said that he was unable to make anytime during week commencing 25 February so arrangements were made for the visit to take place on 2 March.

57. The family found the prison family liaison officer's telephone call on the day of the funeral insensitive and inappropriate. The prison family liaison officer said that he knew the date of the funeral but rang in the evening to offer support and to confirm the visit arranged for the following day.
58. The man's brother said that he had been sent to the wrong location for the visit by the prison family liaison officer. The prison family liaison officer refutes this as he remembers providing the man's brother with directions to Pentonville.
59. Family liaison is incredibly difficult attempting to achieve the right balance, of sensitivity with the needs of the family, as well as trying to provide all information to a family in a timely manner. He is a trained family liaison officer who has acted in other cases without complaint. I accept that the prison family liaison officer performed the duties as family liaison officer to the best of his ability.
60. I can appreciate and sympathise with the family's feelings. The prison family liaison officer will wish to satisfy himself that liaison officers have the necessary skills and are supported in their role.

Transfer of information

61. The man's family wanted to know how much information, if any, was transferred from the police authorities to the prison service on his remand to Pentonville. They explained that the man had been known to the police for approximately two months prior to his remand under two names and were fully aware of his background, his previous suicide attempt, and vulnerability and alcohol dependency. The man's family are very concerned that none of this vital information was passed to the prison service. It is beyond my terms of reference to investigate the actions of the police. As such I am unaware what information regarding any previous self harm, suicide attempt, drug or alcohol issues were known to the police under the man's former name.
62. The investigator was told by the police that their records showed that, under his former name the man had a criminal record and had served a number of custodial sentences. The alleged offence which the man had been remanded into custody was the only occasion he had been in prison under that name.

63. The investigation has established what documentation arrived with the man when he arrived at Pentonville from court. This did not include any detail of his previous convictions, nor did it identify him as having any physical or mental health concerns or that he may be at risk of self harm. In addition the man chose not to inform staff that this was not his first time in custody or that he had previously attempted suicide in the past. The man's family told my investigator that this suicide attempt dated back to 1988. Whilst previous attempts of self harm or suicide are known risk factors, it is unlikely that any attempt of some 23 years ago would have led to an ACCT being opened by prison staff without other corroborating risk factors being identified.
64. The man was asked appropriate questions during his reception and induction regarding self harm, mental health, alcohol and substance misuse. He chose not to tell staff of his background. Had he given different information, I would have expected staff to have taken the necessary steps to support him. However, I am satisfied that staff at Pentonville acted appropriately when the man arrived in custody. .
65. However, the police told my investigator that the names were linked in the police records and the police were therefore aware that this was the same person. Key information about a person's criminal convictions, past custodial history and in particular any vulnerabilities should always be effectively shared between the police, courts and prison. The PER form is designed to ensure that important information is effectively transferred between the police, courts and prison and it has recently been redesigned to capture this more thoroughly. I can not say what information the police had regarding the man's risk factors. I am concerned that the man's former name was not identified. Investigation into police matters are outside of my remit, however I will be sending a copy of this report to the Commissioner of the Metropolitan Police in order to draw his attention the matter.

The man's correspondence

66. The man's family wanted to know if the man's letters had been monitored as the content of a letter he had sent to his friend, the family believe, was a clear indication that something was not right and would like to know if this information had been identified by the prison service.
67. Prison Service Instruction (PSI) 06/2011 'Prisoner Communications – Correspondence' details the procedures prisons must follow for handling prisoners' correspondence. For a prisoner's outgoing correspondence the instruction states:

“Outgoing correspondence need only be examined where (i) routine reading is in force, (ii) there is a special instruction to read the prisoner's correspondence, or (iii) there is reason to believe that

restrictions on the enclosure of other articles and papers have not been observed.”

68. The investigator has established that the man’s outgoing correspondence was not monitored. Only high risk prisoners at Pentonville have their outward correspondence checked by staff and the man was not a high risk prisoner. All incoming mail for all prisoners is opened and checked for security reasons, but again only the mail for high risk prisoners is monitored.
69. I understand why the man’s family are concerned by the letter he wrote. However, I am satisfied that the prison acted in accordance with policy by not checking his mail.

The man’s property

70. The man’s family believe that the man was refused a phone pin number and had not been allowed a pair of shoes, with laces, and was being denied his basic privileges.
71. The investigator has found that the man was given a phone pin number and was authorised to contact his friends and his legal representative. The prison family liaison officer explained at interview that it takes a couple of days to set up a phone card account as the numbers that a prisoner wishes to call have to be checked for security reasons before they are authorised.
72. A prisoner’s personal property is logged on individual property cards (F2056C and F2056D). Upon review of the man’s property card, the investigator found that the man received a pair of Clark’s shoes and a belt on 15 January 2011 when they were received on a visit to the prison. When the items were given to the man, he signed to say he had received them. The prison liaison officer confirmed that the man would have received the shoes with laces as there was no reason for staff to remove them as he had not been assessed as a risk to himself. In addition the man received a Sekonda watch via the post on 27 January 2011 and again signed that he had received it.

CONCLUSION

73. The man was in prison for a little under a month before taking his life, during this time he clearly maintained a low profile and exercised his right to withhold from staff his previous name, medical and previous custodial history.
74. However I am concerned that key information which linked the man to his previous name and showed a record of convictions, previous custody and any known risk factors was not effectively shared between the police, court and prison.
75. Staff at the prison were only able to act on what the man told them, and I therefore judge that there was appropriate assessment made of the man's physical and mental health and appropriate treatment and care was provided. I agree with opinion of the clinical reviewer that the standard of health care the man received at Pentonville was equitable to that which he could have expected to receive in the community.
76. When the man was found hanging, staff responded swiftly and with professionalism. I would like to recognise the professionalism of all the staff who responded that morning.

The Prison Service, having read the report, wish to comment that they remain satisfied with the performance of the prison family liaison officer.

The man's family, having had the opportunity of reading the report at the consultation stage of the process, wish to make the following comments:

In conclusion, the family feels that communication with family liaison was difficult at times. However, with the passing of time they are prepared to accept that they were deeply upset, angry and confused and that their emotions certainly played a part in some of the confusion. The family also accepts that with the passing of time, they are aware that the role of dealing with bereaved families is a delicate one but would suggest that extra measures such as text messaging or emailing directions to the prison would have been fairly easy to do.

The family does however feel that the failure to pass vital and clearly known information from the Police to the prison staff was a disastrous failure of care and whilst it can never be proven as to whether the sharing of information would've prevented the fatality, there is no doubt that it would've flagged up concerns for the prison staff.

Lastly, the family would like to acknowledge that having read the transcripts, it is clear that the emergency care that the man received was exemplary and wish to extend their gratitude to the staff and all attendees to the fatality.

