

**Investigation into the circumstances surrounding the
death of a man at HMP Pentonville
in March 2008**

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

December 2009

This is a report into the death of a man at HMP Pentonville in March 2008. A sentenced prisoner awaiting trial on a further charge, he was found hanging in his cell around 5.15am. He was 24 years old. The man was held in custody under another name and claimed to be an American citizen. Only after his death was his real identity discovered along with the fact that he was a Ghanaian national.

I offer my sincere condolences to the man's family and friends for their loss. The death of a loved one in these circumstances, so far away from home, must add to their sorrow. I regret the delay in issuing my report and the additional distress that this may have caused.

The investigation was led by my one of my investigators. He was assisted by an Assistant Ombudsman. I thank the local Primary Care Trust for appointing an independent clinical reviewer. I am also grateful to the Governor and staff of HMP Pentonville, especially the Governor whose assistance was a great help to my investigators. My Senior Family Liaison Officer liaised with the man's fiancée throughout the investigation.

The man's immigration status and his false identity seem to be at the heart of this tragic story. However, while I am critical of aspects of the ACCT process at Pentonville, I do not believe that the staff charged with his care could reasonably have predicted his actions.

I make eight recommendations and one commendation.

This 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.

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Prisons and Probation Ombudsman

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SUMMARY

The man was first detained under immigration powers on 26 August 2007, having arrived at Holyhead in North Wales from the Republic of Ireland. He was carrying a United States passport with a forged bio data page in another name. He was detained and eventually sentenced in this name, and maintained throughout that it was his true identity and that he was a United States citizen. His fiancée told my team that she knew him by the same name and nationality. It was only after his death that his true identity and nationality as a Ghanaian citizen were established.

He appeared in court on 27 August, charged with possession of a false passport, and was remanded into custody at HMP Liverpool. He was assessed by reception staff as being of low risk of self harm.

After his committal on 7 September to the Crown Court for trial, he transferred to HMP Altcourse. Assessment, Care in Custody and Teamwork (ACCT) procedures to reduce risk of self-harm and suicide were opened on 11 November because monitoring of his letters found references to killing himself. He was concerned that the court case questioned his identity, that his fiancée might not believe him and that he would suffer a legal injustice. An immediate ACCT action plan was put in place which included frequent observations by officers and regular conversations. The support of his fiancée and his thoughts about the child they were expecting were recognised as factors that should protect him from harming himself. His ACCT document was closed five days later.

The man was convicted for possessing the forged passport and sentenced to 12 months imprisonment. The judge made no recommendation about deportation although this could reasonably have been anticipated. On 4 December, he was notified of his conditional release date of 25 February 2008 and sentence expiry date of 26 August 2008.

Altcourse transferred him as a sentenced prisoner to HMP Bullingdon on 10 December. Transfer and reception assessments indicated that he was again judged to be low risk of self harm.

The Border and Immigration Agency (BIA) (now UK Border Agency) served the man with a notice of the liability to deport on 16 January 2008. He indicated his intention to appeal against the deportation. He was served with the notice of the decision to deport him on 18 February, together with the reasons and his right of appeal. In response, he wrote a letter in which he said he had decided to take his own life as he refused to be in prison after 25 February and that, "I cannot continue living in prison after my sentence." In another letter to BIA, he asked for release from Bullingdon, quoting immigration law and human rights rulings that immigration detainees should be held in immigration removal centres after the expiry of their sentence.

That same day, the man threatened to hang himself if he was not released or deported on 25 February. A senior officer immediately opened another ACCT document. Records indicate that he was depressed by the problems stemming from his immigration status. He was seen by the prison's doctor the following day, by

which time he said that he was no longer suicidal. The doctor indicated that he would need more support around his conditional release date.

Further correspondence from BIA informed the man that permission to enter the country under bail conditions would not be granted, but that he could appeal to an immigration tribunal. On 27 February 2008, the Asylum Immigration Tribunal notified him that the appeal hearing would be on 27 March. On 29 February, the ACCT was closed.

On 1 March, an ACCT was opened immediately after the man's cell mate found him with a bed sheet ligature around his neck attempting to hang himself. He was admitted to the healthcare centre and placed in a reduced risk cell, with frequent observations by officers. Immigration issues were identified as the main reason why he had harmed himself. He was given an international telephone call, recorded as to his family in America, and was described as feeling better afterwards. He said that his fiancée and child were his reasons for coping, and that he did not want to stay in prison but to go to America. The ACCT action plan was due for review on 7 March.

The man was taken to Stratford Magistrates Court on 7 March to answer a further charge of conspiracy to defraud. He was remanded into custody to appear before the Inner London Crown Court in May. Instead of returning to Bullingdon, he was transferred to HMP Pentonville afterwards. He remained on an open ACCT and hourly observations continued. He was described on the first night as settling in well with his new cell mate, although a little tearful.

On 9 March, the man was allowed a telephone call to his fiancée by the senior officer who later undertook the ACCT review. The senior officer recorded that he was more positive, that he intended to speak to his solicitor, and that he had settled into the wing regime and wanted to start education. The ACCT was closed without a post-closure review being arranged.

Further correspondence from BIA on 25 March refused the man's temporary release to the UK and indicated that he would remain in custody at Pentonville until the Crown Court hearing on 7 May. Correspondence from the Immigration Appellate Authority indicated that the appeal hearing scheduled for 27 March was adjourned until April. In a letter to BIA, the man referred to a visit from the US Citizens Service on 25 March.

A fellow prisoner told the investigation that he saw the man in reception on 28 March. He said that he had been expecting a visit from the immigration authorities, but that they had not arrived and he was very frustrated that the meeting did not take place. However, this prisoner did not think he was at risk of harming himself.

The man wrote three letters. One was to the BIA official dealing with his case, and another to the US Citizens Service asking that they inform his aunt of his death. The last was to his fiancée and to unborn daughter, apologising and saying he could not go on in prison as he was suffering too much.

One morning in March, a uniformed member of staff made a routine check and looked into the man's cell. He was hanging from a ligature tied to the window bars.

Staff responded quickly to the call for emergency assistance. Cardio pulmonary resuscitation (CPR) was carried out until the paramedics arrived some 20 minutes later. The paramedics pronounced that he had died at 5.47am.

THE INVESTIGATION PROCESS

1. My investigators visited HMP Pentonville and spoke to staff who knew the man. They interviewed 18 members of staff and one prisoner. Notices were posted to staff and prisoners inviting contributions to the investigation. The investigators studied all relevant prison records including his main prison record, medical records and the statements made by staff.
2. The local Primary Care Trust identified a medical practitioner to carry out a review of his clinical care. I am grateful to the Senior Practitioner-Practice Nurse for undertaking the review. My investigators discussed aspects of his treatment with both healthcare staff at HMP Pentonville and with the clinical reviewer.
3. My investigators contacted HM Coroner for St Pancras to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report which was made available. Upon completion, my report will be sent to the Coroner to assist his enquiries into the man's death.
4. My Senior Family Liaison Officer contacted the man's fiancée to inform her of my investigation. The Senior Family Liaison Officer has spoken to her on a number of occasions throughout this process. The man's fiancée raised a number of issues she wished to be considered by my investigators, and I hope that my report provides answers for her.

HMP PENTONVILLE

5. Pentonville is a local prison serving the London courts. Built over 150 years ago, it has an operational capacity of 1,150 prisoners. Around a quarter of the population are foreign national prisoners.

Healthcare

6. Pentonville has a new purpose-built healthcare centre 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 other more specialised services. The prison's clinical governance board has a strategy to improve assessment and delivery of treatment to prisoners within their first 48 hours of arrival.

Previous deaths at HMP Pentonville

7. This is the 12th death at Pentonville that my office has investigated since I became responsible for investigating all deaths in prison custody in April 2004. The main issues raised by the circumstances of the man's death are different from those raised in my previous investigation reports.

Night state

8. At night, when the prison is locked up, the number of staff on duty is much lower than during the day and only one of the prison gates may be opened for emergency access. The Night Orderly Officer (NOO) is in overall charge of the prison and visits each wing at intervals. The wings are in the care of night patrol officers who are responsible for monitoring security and safety. The number of officers on patrol varies from wing to wing and includes prison officers and operational support grade (OSG) staff. The NOO carries cell keys but the wing officers carry only cell keys in a sealed pouch for emergency use only.

Assessment, Care in Custody and Teamwork

9. ACCT has been introduced at all prisons. It is a care-planning system whereby staff can work together to provide individual care to prisoners identified as being at-risk in order to help defuse a potentially suicidal crisis or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

Samaritans and Listeners

10. The Samaritans is a national voluntary organisation that provides a confidential telephone support service for people in distress or at risk of harming themselves. Listeners are prisoners selected, trained and supported by the Samaritans to provide a similar service in custody.

Conditional Release, Licence and Sentence Expiry Dates

11. All prisoners given sentences of between 12 months and four years imprisonment are released automatically, but conditionally, at the half way point of their sentence, unless they are subject to other periods of remand in custody or lawful detention. A prisoner released on their conditional release date is subject to licence conditions that require, among other things, their supervision in the community by the probation service. The period of supervision extends to the licence expiry date, and in the meantime the prisoner may be recalled into custody. Some prisoners may be released earlier than their conditional release date on home detention curfew and are subject to electronic monitoring. Foreign national prisoners are not eligible for release on home detention curfew.
12. The sentence expiry date is the date when the whole period of the sentence is complete. A 12 month sentence expires when the whole period has been served.

Her Majesty's Chief Inspector of Prisons

13. The most recent inspection of Pentonville by HM Chief Inspector of Prisons was unannounced and took place in June 2006. Some of the issues raised in her report are pertinent to the circumstances of the man's death. The inspection found that work with foreign nationals had improved. However, HM Chief Inspector reported that there was a group of foreign national detainees who were frustrated by the lack of information and advice about their immigration and detention status.
14. HM Chief Inspector commended the establishment of a foreign nationals committee which had drawn up a new policy for working with foreign national prisoners. She recommended more regular meetings and an action plan to oversee the development of provision. She said that the foreign nationals co-ordinator should organise regular information and support groups for detainees, to be attended by an independent immigration advice agency.
15. HM Chief Inspector repeated an earlier recommendation that ACCT reviews should be multi-disciplinary, noting that some were only attended by a senior officer and the prisoner. She particularly mentioned that the foreign nationals coordinator had not been invited to ACCT reviews of foreign national prisoners.

Independent Monitoring Board (IMB)

16. The IMB annual report on Pentonville for the year ending 31 March 2008 noted some progress but reported that "a comprehensive regime for foreign nationals is still lacking". The IMB said that the foreign nationals coordinator still worked largely alone and focussed mainly on individual immigration matters. It welcomed plans to increase the number of officers which it was hoped would enable the re-establishment of foreign national support groups.

17. The IMB noted that United Kingdom Border Agency (UKBA) immigration caseworkers visit Pentonville on two days each week to hold surgeries on each wing, and that the independent Detention Advice Service visits regularly. Additionally, the IMB commended the presence of foreign national liaison officers on each wing, supported by a dedicated team of prisoners working as foreign national orderlies.

KEY FINDINGS

18. On 25 August 2007, the man was arrested at Holyhead, North Wales, travelling from the Republic of Ireland into the United Kingdom on a United States passport in an assumed name. He was arrested as the passport had a forged bio data page. He was served with an immigration detention document (IS91) following interview under caution as a suspected illegal entrant.
19. Subsequently, the man was charged with deception, specifically “possessing a false identity document with intent to establish registrable facts” (i.e possession of the passport). He appeared at Ynys Mon/Anglesey Magistrates Court on 27 August and was committed in custody to appear before Mold Crown Court for trial. He was taken from court to HMP Liverpool.
20. On reception at Liverpool, the man gave his address as Upminster, Essex, where he said that he lived with his fiancée, who he identified as his next of kin. A cell sharing risk assessment (CSRA) to assess his suitability for sharing a cell with another prisoner was undertaken and identified him as low risk.
21. At a Crown Court appearance on 7 September 2007, the man was remanded in custody and transferred to HMP Altcourse. The Prisoner Escort Record (PER) is a record of all escorted journeys made by a prisoner. It includes a section highlighting any known risks including potential self-harm and medical issues. The PER for his journey to Altcourse identified no risks, and the CSRA completed in reception assessed him as low risk and suitable for sharing a cell, preferably with a non-smoker. Between September and early November, the records show that the man had settled and scored well on the incentives and earned privileges scheme (IEP). He was described as generally co-operative and helpful.
22. However, monitoring of the man’s letters revealed references to him taking his life and to his fiancée not believing who he was. Consequently, on 11 November, an Assessment, Care in Custody and Teamwork document (ACCT) was opened. During the initial ACCT interview, he said he had thought of suicide in the previous weeks and especially that day, although he emphasised that things were “fine” between him and his fiancée. He said he had thought of jumping from an upstairs landing onto his head. He was described as withdrawn and it was noted that he did not come out of his cell very often.
23. The immediate ACCT action plan to reduce his risk included five observations per hour, with three significant conversations per shift, living in a shared cell, and telephone access to the Samaritans and contact with a Listener.
24. The ACCT assessment the following day recorded that the likely triggers of self-harm were the man’s communications with the court, with his solicitor and with his family. The assessment identified that he was concerned that he had been wrongly accused and did not want to suffer an injustice in the court. He expressed concerns that the court said he was a different person to who he

said he was and that he felt “torment” in prison but did not want to kill himself. The support of his fiancée and his thoughts about his unborn child were expected to help to protect him from harming himself. The man was assessed as more positive with no thoughts of self-harm, and he was encouraged to maintain good contact with his fiancée and his solicitor. The ACCT observations were suspended and the significant conversations reduced to twice a day.

25. The ACCT was reviewed with the man on 16 November. Due to his level headed approach to his problems, it was closed with a post-closure review set for 23 November. The post-closure meeting was actually undertaken on 24 November. It recorded his plans for beginning education classes. He was looking forward to a visit from his fiancée, and was settled with his cell mate. He was aware of the availability of Listeners and the Samaritans should he need them.
26. The man appeared before Mold Crown Court on 22 November, and was found guilty of possession of a forged passport. On 30 November, the same court sentenced him to 12 months imprisonment. The judge ordered that the 95 days he had spent on remand should be taken into account. There was no recommendation from the judge regarding deportation and the man returned to Altcourse.
27. On 4 December, the man was given his sentence calculation dates. His conditional release date was set at 25 February 2008, and his licence and sentence expiry dates as 26 August 2008. There is no record of his reaction to the information.
28. As Altcourse is primarily a remand prison holding only a few sentenced prisoners, the man was transferred to HMP Bullingdon on 10 December. The Prisoner Escort Record (PER) document prepared for his transfer identifies no risks. At the CSRA undertaken on reception at Bullingdon, he was recorded as not being on an open ACCT, and was deemed to be low risk and suitable for sharing a cell. The induction healthscreen noted that he was not having any thoughts of deliberate self harm.
29. There is a record that the man was taken to Milton Keynes Magistrates Court on 18 December but no indication as to why this happened.
30. The man applied on 7 January 2008 to leave the UK under the Facilitated Return Scheme (FRS). (The FRS is a voluntary scheme run by the UK Border Agency to help prisoners from outside the European Economic Area to return home. It pays for travel and provides some financial assistance.) However, he withdrew his application on 10 January following advice from his solicitors.
31. On 16 January, the man was served with a notice of liability to deport by the Border and Immigration Agency. Prison records show that he was given the notice on 17 January. He completed the attached questionnaire which he returned on 6 February. While the prison record does not clearly indicate his

response, it is clear from later documentation that he appealed against deportation. A subsequent letter from BIA indicates that he also wrote on 4 February asking to be released on bail at the discretion of the Chief Immigration Officer (referred to as CIO bail).

32. On 18 February, BIA served the man with a notice of the decision to deport. The reasons given included that he had been convicted of possessing a forged passport that he gave a false identity, and had failed to substantiate any of his history within the UK. Furthermore, the notice letter noted that he was not “asking for residency, citizenship or seeking asylum”. It concluded that it was appropriate to deport him to the USA. At the same time, he was served with further IS91 detention documentation authorising his continued detention beyond his conditional release date of 25 February.
33. The man wrote a long letter, dated 18 February, in reply to the notice. It was headlined with the request ‘please release my corpse to my family’. He wrote:

”I have decided to take my own life. Because I refuse to be in prison after 25 February 2008. It is better to die than continue suffering for a crime I did not commit ... I cannot continue living in prison after my sentence.”
34. In a further undated letter around the same time, again in response to the deportation notice, the man asked for a transfer to an immigration removal centre following his conditional release date of 25 February. He supported his request by quoting from the Nationality, Immigration and Asylum Act 2002 and European Court of Human Rights rulings, and argued that detainees should be held in immigration centres after the expiry of their sentence. He said that his human rights would be breached if he remained in prison after his conditional release date.
35. There is no record that the man was given an explanation for his continued prison detention beyond 25 February. However, the BIA letter to him dated 18 February made clear that he had impending prosecutions for other offences. Furthermore, in a letter dated 26 February declining his request for CIO bail, BIA specifically mentioned that he had a pending prosecution for fraud for which he would be appearing at Stratford Magistrates Court on 7 March.
36. The man made a noose and threatened to hang himself on 18 February. The wing senior officer opened an ACCT document. The document was not found amongst the records provided by Pentonville for this investigation.
37. The medical records show that the senior officer telephoned a Staff Nurse to ask a nurse to assess the man as part of the ACCT process. She responded that, due to a staff shortage, it was impossible for her to go to the wing to see him. She offered advice over the telephone instead. It was agreed to place him on frequent observations and that healthcare would be kept informed. The Staff Nurse subsequently spoke with a Senior Officer (SO) who said that the man was worried about immigration issues and wanted to be deported or bailed on 25 February. She described him as depressed but able to remain

on the unit, and asked for him to see the doctor the following day. He was placed on the doctor's list.

38. A prison doctor saw the man on 19 February and confirmed that the main issue was his immigration status, as he did not want to be held longer than his sentence. She recorded that he said he did not want to kill himself and had no active plans to do so. She assessed his current situation and did not consider that any medication was necessary. She identified that his situation might deteriorate the following week when his sentence expired, and he might need further support at the time.
39. A memorandum was sent to the discipline office at Bullingdon from the wing senior officer on 19 February. It advised that BIA needed to be informed in line with mandatory requirements that the man, as a potential deportee, had been placed on an ACCT document. The memorandum said that he wanted his letters of 18 February faxed to BIA, and had said he would kill himself if he was not deported or released on 25 February. The records indicate the information was faxed as the man had asked. A fax was also sent to BIA containing the IS91RA risk factor checklist which details any risks presented by a person subject to detention and potential deportation. The checklist had initially been completed indicating that the man was low risk, but was amended with the comment that he had since threatened to harm himself and was now on an open ACCT.
40. There is a copy of a letter dated 20 February which the man wrote to his solicitor. The letter referred to the BIA letter of 18 February noting that he had impending prosecutions, and that he had written requesting transfer from Bullingdon on 25 February. He wrote, "I am innocent of the allegation and nobody believes me but God knows." He continued, "The criminal charge against me is damaging to my soul and reputation." He asked his solicitor to let him know the date and venue of the court and wrote, "I need to be home before my daughter is born."
41. During the next week, the man received a letter dated 26 February from BIA refusing his release on CIO bail. The letter specifically identified that he would be taken to Stratford Magistrates Court on 7 March.
42. Bullingdon received a fax on 27 February from the Asylum Immigration Tribunal (AIT). It confirmed the man's appeal hearing at Birmingham on 27 March and asked for escorts to be arranged. A note on the fax indicated that the date should be entered on the Local Inmate Database System (LIDS, the Prison Service database), with a note that escorts should only be arranged following the outcome of the court hearing on 7 March.
43. Subsequent records indicate that the man's ACCT document was closed on 29 February. The circumstances are not known as the ACCT document is not on file.
44. The following day (1 March 2008 at 4.30am), the man's cell mate heard a noise and found him attempting to hang himself. He had used a bed sheet

ligature tied to the bed. The cell mate freed him from the ligature. An ACCT was re-opened immediately. He was assessed by a Nurse and a SO, who found him aware and oriented. He was immediately moved to a reduced risk cell in the healthcare centre. He told the staff that he wanted to go home as all his friends had been removed to immigration centres and he had been left behind. Initially he was placed on frequent observations, which were reduced later in the day to five per hour. He was informed about the support available from the Samaritans and Listeners. He was seen by a second prison doctor and said he was no longer suicidal. He wanted to go back to the wing, and asked for an international telephone call.

45. The full ACCT assessment interview took place on 2 March. The triggers were identified as immigration issues. The man said his problems were that he had pleaded guilty even though he was not, and he would not get a fair trial. He was appealing against deportation and hoped to delay it until his child was born. He wanted to go back to America, but not whilst his fiancée was pregnant. He said he thought that hanging himself was the only way to deal with his problems. However, he said he was no longer suicidal and he could cope because of his fiancée, his unborn child, and his wish to return to America. The review decided to keep his observations to hourly, move him to an ordinary cell with a television, and encourage him to talk to staff. The next ACCT review was set for 7 March.
46. On 3 March, the man was given an international telephone call, which was recorded as to his family in America. He was noted as being more positive afterwards, having sorted out a lot of his immigration problems.
47. Over the next few days, the man was recorded as dealing well with the paperwork relating to his refused bail application and with other immigration issues. He was admitted to the healthcare centre for an unrelated matter and the medical record entries indicate he repeatedly denied having suicidal thoughts. On one occasion, he mentioned looking forward to the birth of his daughter.
48. On 7 March, the man was taken to Stratford Magistrates Court to answer the charge of conspiracy to defraud. The record does not show whether he expected to return to Bullingdon. Stratford Magistrates Court remanded him in custody to appear before Inner London Crown Court on 7 May.
49. The man was transferred to Pentonville after the court hearing. The PER record showed indicators for a 'mental condition' and 'suicide/self-harm'. It recorded that he was on an open ACCT document, and subject to hourly observations. The open ACCT document travelled with him in line with requirements.
50. The cell sharing risk assessment undertaken at reception at Pentonville recorded the man as a remand prisoner and a detainee charged with deception. It assessed him as being a low risk, and on an open ACCT. A Nurse undertook the initial health screening and assessed him as showing no mental health problems, with no deliberate thoughts of self-harm, and with a

normal mental state. She told my investigators that she signed the CSRA before seeing the ACCT document due to the procedure then in place in reception. The CSRA was signed off by a SO, who also undertook the first night interview with him and concluded that he was suitable to share a cell.

51. The ACCT record of observations for 7 March described the man as “seems ok, although a bit tearful” following his arrival at Pentonville. Later in the evening, the wing Officer recorded him as settling in well with his new cell mate having been moved from a smoker’s cell. The man was chatting and writing letters.
52. On 7 March, a letter from the Asylum Immigration Tribunal was faxed to Bullingdon (it was faxed to Pentonville on 10 March). It said that the man’s appeal hearing, which had been due on 27 March, was now adjourned until 17 April in Birmingham. The letter asked that escorts be arranged for the new date. The records do not show clearly if and when the man was informed of the adjournment.
53. The ACCT document was due for review on 7 March but, due to the man’s production at court and transfer to Pentonville, this did not happen until 9 March. The hourly observations continued until the review. An SO undertook the review alone with him. He recorded that he was more positive. The man had accepted that he might not get bail, but would see his solicitor the following day. The ACCT assessor described the man as settled into the wing regime and wanting to start education as he had at Bullingdon.
54. The ACCT assessor closed the ACCT document on 9 March, two days after the man’s arrival at Pentonville, and without setting a date for a post-closure interview. He told my investigators that closed ACCTs would be given to the Safer Custody Co-ordinator who would then organise the reviews.
55. The ACCT assessor allowed the man two telephone calls to his fiancée, one before the ACCT review and another on 10 March, as well as a call to his solicitor the same day.
56. A letter from the fiancée’s Member of Parliament was faxed to the prison on 19 March. It followed representations from the fiancée and requested confirmation of the man’s status as a detainee. There is no record of a response to the letter.
57. On 22 March, the man was given his secondary health screen check by a Nurse. It was late - some two weeks after his reception into Pentonville - but did not record anything of concern. There are few other records involving him over the next days. He was recorded on 23 March as a man who “complies with the regime and causes no problems”.
58. A further letter dated 25 March from BIA was faxed to Pentonville. It was in response to a request made by the man on 18 March, requesting release on Home Detention Curfew. The letter reiterated the reasons why BIA refused temporary admission on bail. They included the judge’s refusal of bail in

respect of the fraud charge, and the letter concluded that he would remain in Pentonville until the Crown Court hearing on 7 May. The letter did not explain that foreign national detainees are not eligible for release on home detention curfew.

59. It is not clear when the letter from BIA was given to the man. However an Officer told my investigators he remembered giving it to him on or around the day it arrived, at the request of one of the immigration officials working in the prison. He recalled that the man said he had received the information before, and did not appear shocked, although he had not read all the details. The foreign national coordinator also recalled giving him some other immigration related paperwork, but could not recall when that was.
60. In a subsequent letter, the man said that he had received a visit from a representative of the Citizens Services at the United States Embassy on 25 March. There are no details of the substance of the visit.
61. There is a copy of a letter dated 27 March written by the man to the Independent Police Complaints Commission (IPCC). He asked the IPCC to investigate what he described as a false claim about his DNA data. It is not clear whether the letter was actually sent.
62. A fellow prisoner (who is trained as a Listener, but did not know the man in this capacity), told my investigators that he saw him in reception on 28 March. He understood that he was there as he was expecting a visit from the immigration authorities but they had not arrived. He said that the man was very frustrated as he had been building himself up for the meeting. It is not clear, either from the records or from interviews with my investigators, why he was taken to reception on at least one occasion on 28 March.
63. The Listener knew that the man's fiancée was due to give birth, and that he wanted to be released before the baby was born. He did not think that the man was at risk of harming himself. He thought that he was not well known on the wing as he had only been there a short time. He could speak English well enough to make himself understood.
64. In March, the man was locked in his cell as usual. He had been sharing a cell, but was alone that night as his cell mate had been moved. He wrote three letters during the night which were found after his death. The first was to the BIA caseworker saying that his dead soul would have vengeance. A second was addressed to the US Embassy representative, asking him to inform his aunt in America of his death. The final letter was to his fiancée and unborn daughter, apologising as he was suffering too much in prison and could not go on.

Events in March

65. At 5.15am, the night patrol officer, Operational Support Grade (OSG), was carrying out routine cell checks when he looked through the door flap of the man's cell. He saw him hanging by a ligature tied to the window bars, with his

feet on the floor. He rapidly called for help from a night Officer, who immediately called communications over his radio to raise the alarm. The night Officer broke open his sealed keys, quickly opened the door and went into the cell. Several other officers arrived within a minute or so, and the man was released from the ligature and placed on the floor.

66. The SO (Night Orderly Officer in charge of prison) had commenced unlocking the prison around 5.00am. As he approached the centre office, a member of staff shouted at him and said there had been an incident on G wing. Staff had apparently tried to contact him via his radio. The SO told my investigators that he then discovered the batteries in his radio were dead. He made his way immediately to G Wing to find healthcare staff trying to resuscitate the man.
67. The night Staff Nurse arrived rapidly. She examined the man but was unable to find a pulse or signs of life. She immediately began cardio pulmonary resuscitation (CPR), and called for a defibrillator (a machine that applies electrical impulses to the heart and advises whether there is any rhythm which might be stimulated). It arrived quickly and, once applied, advised to continue with CPR. A second night Officer took over applying CPR for some 15 to 20 minutes before the paramedics arrived. This must have been physically and emotionally draining.
68. An ambulance was called at 5.25am. It arrived at 5.35am, but at the wrong prison gate entrance. A second ambulance arrived at 5.38am, and at 5.40am, the paramedics arrived at the cell. They took over CPR from the prison staff and examined the man. At 5.47am, the paramedics confirmed that he was dead.
69. Staff found the letters the man had written. They were laid neatly on the table under a covering piece of paper asking that they be posted. The cell was sealed to await the arrival of the police.
70. The prison's action plan in the event of a death in custody was initiated by the Duty Governor. The governing Governor, chaplain, head of healthcare, and safer custody co-ordinator were all informed. The police were called and arrived at 6.15am. The Coroner's officer arrived at 7.28am. The police forensic medical examiner subsequently confirmed that the man had died. The undertakers left the prison with his body at 1.10pm.
71. A 'hot debrief' meeting was convened by the Governor attended by the staff who had been involved. It gave the staff some immediate support and opportunity for reflection. Staff told my investigators that a critical incident debrief was held subsequently, and was also well attended. However, the second night Officer, who had been so intimately involved in giving CPR, was unable to attend that debrief and had no further contact or offer of support for some six weeks.

72. A notice to prisoners was issued informing them of the man's death, advising of support available and offering the opportunity of support from the chaplain if they wished.
73. The Duty Governor was appointed as the prison's Family Liaison Officer. He told my investigators that normally he would have gone personally to the man's nominated next of kin, his fiancée, but because of the pressures at the prison he arranged instead for the police to inform her of his death. This was done around 9.30am. The Duty Governor spoke with her by telephone at about the same time.
74. The Duty Governor maintained regular telephone contact with the man's fiancée up to the end of April, except during the period when she gave birth to her daughter. He was able to give her a copy of the letter the man had left her. The Duty Governor also offered to meet with her if she had any concerns that she wished to raise. The fiancée told my Senior Family Liaison Officer that she felt that the prison had been very helpful to her.
75. The post mortem was carried out by the Consultant Forensic Pathologist on 31 March. He concluded that the cause of the man's death was hanging, consistent with self suspension.
76. The man's identity was established by the police and Coroner after his death. His fiancée was then able to contact his father in Ghana. She told the Duty Governor that the family would like to be involved in the funeral arrangements, and have him flown back to Ghana for burial. Subsequently, the Duty Governor liaised with the man's parents and solicitor in Ghana, and arranged for his body to be repatriated to Ghana. Later, he had a telephone call from the family solicitor confirming that the funeral had taken place.

ISSUES RAISED IN THE INVESTIGATION

Clinical Care

77. I am grateful to the clinical reviewer for undertaking a clinical review on behalf of the local Primary Care Trust. The clinical reviewer makes 11 recommendations which I fully endorse. I emphasise two here for consideration by the Governor and the Prison Service.
78. The clinical reviewer observes that there were some clinical procedural errors on the man's arrival at Pentonville. She highlights that, had his medical record arrived with him and been assessed by the reception nurse, he would have been seen by the doctor that evening and should have been referred for a mental health assessment. Nevertheless, it is impossible to say whether, had these errors not occurred, his suicide would have been prevented.
79. The clinical reviewer indicates that the small delay in the paramedics' arrival caused by the ambulance attending the wrong gate was not significant. On this occasion I agree, although such delays must be prevented in future. The clinical reviewer has recommended that the prison communications team and London Ambulance Service should liaise to ensure that ambulances go to the correct gate. I bring the matter to the attention of the Governor. It is self-evidently of great importance that the prison and London Ambulance Service find a solution to this problem.

The Governor should review the procedure for the attendance of ambulances at the prison to ensure that a system is in place that clearly directs ambulances to the correct prison gate.

80. The clinical reviewer concludes that the nurse, prison officers and ambulance paramedics made appropriate interventions when the man was found hanging and that resuscitation was not going to be successful. I agree with her commendation of the second night Officer, who continued resuscitation for a long period, sadly without success, before the paramedics took over. It is important that such staff receive a proper standard of aftercare.

The actions of the second night Officer should be commended.

81. My investigators found that a significant number of uniformed staff at Pentonville had either not had training in first aid and cardio pulmonary resuscitation or it was out of date. I agree that the prison should ensure that uniformed staff have up to date basic life support skills, which the clinical reviewer says should be revised at least every five years. It should be undertaken as part of a strategy which also ensures there is a sufficient number of trained staff on duty, particularly when the prison is in night state.

The Governor should ensure that uniformed prison staff receive basic life support skills refresher training at least every five years.

82. Many receptions at Pentonville are a consequence of contracted prison escorts not being able to return a prisoner to an out of London prison at the end of the court day. Such unplanned transfers can cause problems for the communication of critical information about prisoners, including their medical records.

The Prison Service should ensure that, where possible, the prisoner's medical record accompanies them during production at court and on transfer between prisons.

Assessment, Care in Custody, and Teamwork

83. My investigators found that ACCT procedures were opened three times: once when the man was at Altcourse and twice when he was at Bullingdon. This final ACCT remaining open when he transferred to Pentonville. There is some evidence of good teamwork undertaken to support him and that he benefited on several occasions.
84. At Bullingdon, ACCT procedures were opened for a second time on 18 February 2008. This followed his response to the notice of deportation, including writing a letter threatening suicide and making a noose and threatening to hang himself. Prison records show that the wing senior officer asked the nurse in healthcare to attend and make an assessment. The nurse said that she was unable to do so due to staff shortages, but gave telephone support to the wing senior officer instead. She also ensured that the man had an appointment with the doctor the following day. It is manifest that, telephone support is not as useful as an initial face to face interview to inform the healthcare contribution to the immediate ACCT action plan.
85. Whether there was sufficient multi-disciplinary contribution during the course of the man's ACCT plan is unknown as, but for a one page document that informs BIA of the ACCT plan, no other records were included in the file at Pentonville.
86. The ACCT document opened on 1 March at Bullingdon was sent with the man when he went to court and they were available when he arrived at Pentonville. However, the reception nurse did not read them before she assessed him. Her failure is dealt with in the clinical reviewer's clinical review. I am pleased to learn that the system has now changed and healthcare staff should have access to ACCT documents before undertaking their assessment.
87. Had the nurse seen the ACCT documents, the man might well have been seen by the doctor on his first evening. PSO 2700 clarifies the responsibilities for sending and receiving prisons when prisoners on ACCTs are transferred. The PSO assumes that such transfers are mainly planned, and allow time for proper communication to occur. Pentonville has problems of prisoners who are unexpectedly remanded in custody by the courts. Nevertheless, the prison should ensure that staff speak with the sending prison as soon as practicable after a prisoner arrives on an open ACCT.

The Governor should ensure that, in line with Prison Service Order 2700, there is a system in place to communicate with the sending prison when a prisoner on ACCT is received into custody.

The Governor, in liaison with the healthcare manager at Pentonville, should ensure that all prisoners received on an open ACCT are assessed by the prison doctor on their first night.

88. An ACCT review was arranged for 7 March at Bullingdon but, unsurprisingly given that this was the day of his court appearance and the man's transfer to Pentonville, it did not actually take place until two days later. When it did happen, only a single senior officer and the man were present. The senior officer told my investigators of the pressures to close ACCT documents, and the difficulties organising reviews because of the high numbers of ACCT prisoners at any one time.
89. I have every sympathy with the prison's pressures. I also recognise that the man presented himself positively in the review in March, three weeks before he took his life. Nevertheless, I consider that closing the ACCT was precipitate given that the man had been in Pentonville for less than two whole days, and that there was no multi-disciplinary representation. I also note that the post-closure review, which would have been an opportunity to reconsider the decision, did not in fact take place.
90. PSO 2700 recommends a graduated closure of ACCT plans, and requires a post-closure interview. Neither the closure of the man's ACCT, nor the system to organise post-closure interviews, met these standards.

The Governor should ensure that ACCT closures are carried out by a multi-disciplinary team and are planned, graduated, and followed by a post-closure review.

91. The foreign national coordinator told my investigators that she did not know that the man had previously been on an ACCT when she served him with some sensitive immigration papers. Serving immigration papers is likely to increase the risk for prisoners. The coordinator relied on wing staff to inform her of prisoners who were at risk of suicide and self harm. The new arrangements which store current and closed ACCTs on the wing may overcome the problem. I also advise foreign national coordinators to refer to a list of the foreign national prisoners who are currently or recently subject to ACCT before serving immigration papers. The coordinators should also ensure that wing staff are asked to monitor any consequent reactions.

Working with Foreign National Prisoners

92. Pentonville has a large proportion of foreign national prisoners, and working with them effectively requires specialist knowledge and training. Much of the necessary information may be provided through the specialist foreign national

coordinators who are supported by BIA (now UKBA) staff who work in the prison. However, my investigators found that weaknesses surrounding the service of immigration papers, and a letter from a Member of Parliament appears to have gone unanswered. Whilst I make no formal recommendation in regard to either matter, I bring them to the attention of the Governor who will wish to improve recording and to arrange for MPs' letters to be answered promptly.

93. Effective management of foreign national prisoners also requires additional knowledge and skills amongst wing uniformed staff. My investigators found that staff had insufficient training. Some progress has been made in response to the recommendations from HM Chief Inspector and the IMB, and thus I do not repeat their recommendations here.
94. The man was plainly distressed by being held in prison beyond his conditional release date, without either transfer to an immigration removal centre or release on bail. He thought that he might be transferred to an immigration removal centre between 25 February and 7 March. He was also distressed at the prospect of his impending trial for a further criminal charge. He had appealed to the immigration tribunal and hoped for bail. It is not clear whether he knew that his immigration appeal was adjourned from 27 March. However, it is clear that, even if the hearing proceeded in late March, he would have still been held in prison custody due to his remand on a fresh criminal charge.
95. PSO 4630 describes the requirements for prisons regarding immigration and foreign national issues. Whilst the prisons holding the man worked within the guidelines, it is not clear that he fully understood the various implications of conditional release dates, licence and sentence expiry dates, eligibility for home detention curfew, and the extent to which further prosecutions affect immigration decisions. Nor is it clear that he understood that his transfer to an immigration removal centre would be a decision for BIA, and that removal centres do not hold prisoners who are on remand on criminal charges.

The Prison Service should review its guidance for working with foreign national prisoners to ensure that the implications of outstanding criminal prosecutions are explained to prisoners who are also held under immigration law.

Prison radio batteries

96. The night orderly officer on duty told my investigators that his prison radio was not working as the battery was not fully charged. Whilst this did not affect the response to the call for assistance for the man, I am concerned that the night orderly officer did not have a fully functioning radio. This is frankly rather shoddy.

The Governor should ensure that prison radios are equipped with fully charged and functioning batteries.

Critical Incident debrief and employee support

97. Following the man's death, the prison organised both a hot debrief and, later, a critical incident debrief for the support of the staff who found him and came to his assistance. However, the second night Officer who undertook CPR on the man was unable to attend the critical incident debrief and was not contacted for some six weeks. I have already commended him for his care of the man, and am disappointed to learn that he felt that he was insufficiently supported afterwards.

CONCLUSION

98. Now that the man's true identity has come to light after his death, there can be no doubt that he must have had many things on his mind. However, at the time he was in custody, he did not speak openly about who he was or how he had come into the UK.
99. We do know that his immigration status caused worry and anxiety from the start of his imprisonment. To add to this, his fiancée was expecting their first child. His anxiety was acknowledged by the opening of an ACCT document at Bullingdon, and he appeared to benefit from the extra support this offered. However, the ACCT was closed two days after arriving at Pentonville. In my view, this was premature as I do not believe staff had had sufficient time to assess and observe him in his new surroundings. The process for closing the ACCT was also flawed. Having said that, he appeared to have settled at Pentonville during his short time there.
100. It seems highly likely that the man's growing concern about his immigration status, the fear that he might not see his child, and the inevitable pressures of living with a false identity, combined to cause him to take the actions he did. However, I do not believe his actions could reasonably have been predicted by those staff charged with his care.

RECOMMENDATIONS

1. The Governor should review the procedure for the attendance of ambulances at the prison to ensure prison communications team and London Ambulance Service have a system in place that clearly directs ambulances to the correct prison gate.
2. The Governor should ensure that uniformed prison staff receive basic life support skills refresher training at least every five years.
3. The Prison Service should ensure that, where possible, the prisoner's medical record accompanies them during production at court and on transfer between prisons.
4. The Governor should ensure that, in line with Prison Service Order 2700, there is a system in place to communicate with the sending prison when a prisoner on ACCT is received into custody.
5. The Governor, in liaison with the healthcare manager at Pentonville, should ensure that all prisoners received on an open ACCT are assessed by the prison doctor on their first night.
6. The Governor should ensure that ACCT closures are carried out by a multidisciplinary team and are planned, graduated, and followed by a post-closure review.
7. The Prison Service should review its guidance for working with foreign national prisoners to ensure that the implications of outstanding criminal prosecutions are explained to prisoners who are also held under immigration law.
8. The Governor should ensure that prison radios are equipped with fully charged and functioning batteries.

The prison Service have accepted all the recommendations

Commendation

1. The actions of the second night Officer should be commended.