

**Report of an Independent Investigation
into the Case of
Mr Atlantic**

**Commissioned by the Secretary of State for Justice
in accordance with Article 2 of the European
Convention on Human Rights**

**Dr Simon Draycott
Chartered Psychologist**

March 2013

This document has been sanitised and redacted in order to ensure compliance with the Data Protection Act 1998. Any information relating to persons or events totally unconnected to the investigation or any sensitive material has therefore been removed. With the exception of the investigation team, actual names have been replaced with pseudonyms.

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Annex 2: Police Custody Records, 19/08/2010 – 21/08/2010

Custody Record Front Sheet, version 1, created 19/08/2010 at 17:06

Risk Assessment, Version 1, 19/08/2010 at 17:18

Custody Record Front Sheet, Version 2, 19/08/2010 at 17:43

Detained Person's Medical Form, 19/08/2010 at 18:41

Detained Person's Medical Form, 20/8/2010 at 00:09

Signature Capture Form One, 19/08/2010 and 20/8/2010

Charge(s) [Form MG 4 charges], 20/8/2010

Detained Person's Medical Form, 20/08/2010 at 17:02

Detention Log, 19/08/2010 – 21/08/2010

Annex 3: Warrant documents

HM Prison Service Stored Property form

HM Prison Service form to the Escort Contractor, to be forwarded to the court room with the defendant

Warrant of sending to Crown Court for trial. Issued at Stratford Magistrates' Court on 21st August 2010

HMP Pentonville form 'Initial Referral Potential Category 'A' prisoner', 21/08/2010.

Annex 4: PER forms

Person Escort Record Form, dated 21/8/2010

Escort Handover Details [re 21/08/2010]

History and Record of Detention and Escort Events, Sheet number 1

PER – Part B, dated 21/08/2010

Annex 5: HM Prison Service. Core record

Annex 6: Medical reports and records

Note entitled 'Further Medical Information' by Sirocco, Legal Rep. Undated

Brief Risk Assessment. Form CPA6. Undated

Nursing Care Plan. Healthcare, HMP Pentonville. Care plan No: 3 (Risk to self)

Self-Harm / Attempted Suicide questionnaire. F213SH.

Medical Officer's report, dated 24/8/2010

Risk Assessment for hospital escort / bedwatch. Dated 24/8/10

Letter dated 19 August 2010 to Mr Atlantic from the Booking Clerk, Barts and The London NHS Trust, regarding his appointment on 24th August 2010, and enclosing information booklet from the Hand Therapy department

Undated letter to whom it may concern, from a member of the Hand Therapy department

Undated letter to Mr Atlantic from a Clinical Nurse Specialist, Barts and The London NHS Trust, regarding his appointment at the Hand Clinic on the morning of 24th August 2010

Nursing Care Plan. Healthcare, HMP Pentonville. Care plan No: 5 (Treatment; e.g. medication)

Discharge Summary – Patient Details, page 5 & 6 of 6. Barts and The London NHS Trust – Patient Copy. 19/08/2010

Registration Details – Patient No: 20200 [This includes a Medical Record.]

Annex 7: ACCT Plan 21/8/10 – 24/9/10

Front cover

Inside front cover

Concern and Keep Safe Form, 21/08/10

Immediate Action Plan, 21/08/10

Assessment Interview, 22/08/10

Action following assessment, 22/08/10

CAREMAP, 22/08/10

Record of Case Review, 23/08/10

Annex 8: ACCT On-going Record, 21/08/10 - 25/08/10

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Incident Form A – Managers report, dated 24/08/2010

Incident Form B – Staff report, dated 24/08/2010

Serious Self-harm Incidents Questionnaire, undated. Completed by the Safer Custody Manager for return to the Safer Custody and Offender Policy Group¹

Annex 11: Serious Incident Investigation report and action plan

NHS Islington. Serious Incident Investigation Report, dated 18 January 2011

NHS Islington. Serious Incident Action Plan [Serious Untoward Incident action plan]

Annex 12: Medical Records Audit

HMP Pentonville Medical Records Audit - EXAMPLE

HMP Pentonville Medical Records Audit November 2010

¹ The Safer Custody and Offender Policy Group is now named the Offender Safety, Rights and Responsibilities Group. It is part of the National Offender Management Service (NOMS), an executive agency of the Ministry of Justice.

Annex 13: Interview transcripts

Staff Nurse Bala
Senior Officer Lindisfarne
Senior Officer Luing
Officer Sheppey
Staff Nurse Colliford
Officer Anglesey
Senior Officer Tresco
Nurse Fonthill
Ms Duich
Governor Alderney
Dr Ness²
Nurse Coniston
Healthcare Assistant (HCA) Strangford
Mr Leven
Nurse Portmore
Officer Bardsey
Officer Mull
Miss Tay
Ms Fada
Staff Nurse Grasmere
Officer Skye
Officer Guernsey
Staff Nurse Tummel
Governor Wight
Officer Oronsay
Mr Atlantic

Annex 14: Nursing and Midwifery Council. Record keeping. Guidance for nurses and midwives. Published in July 2009.

Annex 15: HM Pentonville. Guide to Management Checks of open ACCTs. 2011

Annex 16: HM Prison Service. HM Pentonville Healthcare. Operational Policy for the Inpatient Unit. 04/01/11

² Aka Dr Ness

EXECUTIVE SUMMARY, LIST OF FINDINGS AND RECOMMENDATIONS

EXECUTIVE SUMMARY

The Secretary of State for Justice commissioned me in May 2011 to lead an independent Investigation into the case of Mr Atlantic in accordance with Article 2 of the European Convention on Human Rights (ECHR). This report reflects the findings of the investigation into the nature of an incident of serious self-harm on 24th August 2010 involving Mr Atlantic that led to him sustaining serious long-term injuries, and into the circumstances which surrounded it.

Mr Atlantic was born in Russia in 1968. He has resided in the United Kingdom since 2000. He was arrested on 13th August 2010 on suspicion of committing a double murder, namely of his ex-wife and his ex-mother-in-law, hours earlier. At the time of the alleged offences Mr Atlantic tried to kill himself by self-inflicted stab wounds to his neck, abdomen and both wrists. He then spent six days in hospital being treated for his injuries.

On 19th August 2010 he was transferred from hospital to Forest Gate Police Station, awaiting his Magistrates' Court appearance on 21st August 2010. After his appearance there, Mr Atlantic was transferred from the Magistrates' Court to HMP Pentonville. On his arrival at the prison, an ACCT document³ was opened for Mr Atlantic immediately, and he was put on a constant supervision regime. He was moved from Reception to the prison's Healthcare unit and placed in a gated cell.

Between 21st August 2010 and 24th August 2010, whilst Mr Atlantic was on the Healthcare unit, attempts were made to conduct ACCT and psychiatric assessments with him, but with limited success. Attempts were made to interact with Mr Atlantic by both clinical and discipline staff throughout these three days but his communication was generally limited to talking about his physical needs.

Mr Atlantic was due to make a court appearance via video-link on 24th August 2010. An escort officer informed Mr Atlantic that morning of his impending appearance, and collected him from his cell at the appointed hour. Mr Atlantic and the escort officer were accompanied by a constant supervision Healthcare Assistant (HCA).

On the way to the video-link, as the officer was locking one of the Healthcare doors behind him, Mr Atlantic dived over the nearby first floor, stairwell railings onto stairs below. The alarm was raised, Mr Atlantic was attended to by the medical response team, and taken by ambulance to hospital.

As a result of the injuries he sustained, Mr Atlantic is now paralysed below the chest, but has movement in both arms, his head, neck and shoulders.

³ Assessment, Care in Custody and Teamwork: Care planning system used to help identify and care for prisoners at risk of suicide or self-harm (replaced F2052SH)

The terms of reference for this investigation were as follows:

- to examine the management of Mr Atlantic by HMP Pentonville from the date of reception on 21st August 2010 until the date of the incident on 24th August 2010, and in light of the policies and procedures applicable to Mr Atlantic at the relevant time
- to examine relevant health issues during the period spent in custody from 21st August 2010 until 24th August 2010, including mental health assessments and Mr Atlantic's clinical care up to the point of the incident on 24th August 2010
- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved
- to provide my views on what I consider to be an appropriate element of public scrutiny in all the circumstances of this case

Mr Atlantic was interviewed as part of the investigation and a signed statement was received from him in relation to this interview.

The investigation reports on 17 key findings and makes 23 recommendations.

In terms of public scrutiny, I feel that publication of this report will be sufficient to meet the State's investigative obligation under Article 2 of the European Convention on Human Rights. During our investigation we have not uncovered widespread or serious systemic failures and we therefore believe that a public hearing is not warranted.

LIST OF KEY FINDINGS

General findings, which also in turn relate to other findings listed below

1. We experienced a level of disconnection between clinical and discipline Healthcare staff. An important way in which this manifested itself was the limited sharing of, and opportunities to share, information amongst staff on the Healthcare unit.
2. We experienced a level of disconnection between the main prison and the Healthcare unit. This disconnection was evident in how requirements associated with this investigation were met.

Re the management of Mr Atlantic's ACCT Plan and re record-keeping in general

3. Whilst we found that the ACCT process is generally held in high regard by those involved in it, we believe that more could have been done by Healthcare unit managers to make it clear to staff what they should be aiming to achieve

through the use of ACCT procedures, what part the ACCT documentation plays in this, and to promote joint ownership of ACCT between discipline and healthcare staff.

4. It's likely that a psychiatric assessment would have been attempted whilst Mr Atlantic was in hospital prior to his move to HMP Pentonville. We feel that attempts should have been made by prison healthcare staff responsible for Mr Atlantic's care to source the result of these attempts to help better understand his mental health.
5. We agree with the psychiatrist's decision to stop Mr Atlantic's anti-depressant medication. We do not feel that the cessation of that medication would have had any relevance to the incident of serious self-harm the following day.
6. In light of the short timeframe of a little less than three days, and the poor engagement of Mr Atlantic, we don't think it was possible to determine the severity of the risk beyond the view that he represented a raised risk. In light of this, and in the absence of active self-harm while he was in prison, we see the measures utilised in the prison for his care and management as typical, appropriate and at the limit of what could be provided.
7. We are critical of the quality of the ACCT, Special Observation form and EMIS⁴ (now SystmOne⁵) entries. We feel that more could have been done by those managing and caring for Mr Atlantic to try to build up a coherent and useful picture of him through these entries, putting more emphasis on interpretation rather than observation alone. We acknowledge that some steps have since been taken to address the quality of SystmOne entries and measures are being taken to improve the quality of ACCT entries.
8. In addition to the quality of entries, we discovered a lack of consistency in views among staff as to what should be recorded in ACCT and what should be recorded in EMIS.
9. We think that poor record-keeping extended to who had, and had not, been employed by the Healthcare unit on a temporary basis. We also think that more could have been done by Healthcare senior management to institute and employ quality control procedures when employing temporary staff on the Healthcare unit.
10. We found the proportion of staff in receipt of ACCT training to be worryingly low, especially amongst clinical staff. Poor record-keeping contributed to this. Whilst steps have since been taken to improve records, we remain concerned about the extent to which temporary clinical staff receive an adequate prison induction, and one in which briefing on ACCT procedures is covered.

⁴ Egton Medical Information System Limited. Known as EMIS, this is a primary care computer system used for patient records.

⁵ A clinical software brand supporting the 'one patient, one record' model of healthcare

11. Whilst HMP Pentonville has decided that clinical staff should invariably be utilised for constant supervision duties, we believe there is a strong case for the use of discipline staff for this work in their place.
12. Whilst we are not critical of the nature of the video-link escort as such, we feel the arrangement and planning of it were poor. We have found no evidence that staff came together to discuss the court appearance prior to it taking place, despite the fact that it was documented as a potential trigger point. Part of these arrangements should have included a fuller briefing to the escort officer on the day.
13. Given the fact that there had been no prior incidents of this type in the prison, we think it reasonable that no consideration was given to the suitability of the video-link route itself prior to the incident.

Re the response to the incident of serious self-harm on 24th August 2010

14. The response to the incident from a medical and security perspective was very good; overall, we think the incident was well-managed. The risk of possible spinal injury was identified immediately and dealt with in a manner that minimised the possibility of further injury.

Re the post-incident period

15. We think that more could have been done by Healthcare unit managers to check on the welfare of staff in the days and weeks following the incident. We also think that information could have been disseminated as to what action was being taken as a result of the incident, beyond changes to video-link escort arrangements. The fact that the constant supervision HCA thought Mr Atlantic had died, only to see him in hospital several months later, is a clear indication that this was not happening.
16. We found that some useful actions were identified by the Head of Healthcare and implemented as a result of Healthcare's internal investigation. However, in attempting to change the attitudes and behaviours of staff, we found existing mechanisms to be somewhat narrow, focusing mainly on training, informing and reminding staff.
17. To encourage further learning, we think that more opportunities could be taken by the OSRR Group in the National Offender Management Service (NOMS)⁶, in liaison with the Department of Health, to share information and best practice across prison Healthcare units, and for the OSRR Group to do the same across Safer Custody teams in the Prison Estate.

⁶ The Offender Safety, Rights and Responsibilities Group is a part of the National Offender Management Service (NOMS), an executive agency of the Ministry of Justice.

INFLUENCING BEHAVIOUR CHANGE

A number of the findings described above, and the recommendations which follow in the next section, are concerned with staff attitudes and behaviour. We believe that learning from past mistakes is intimately bound up with trying to change some of these attitudes and behaviours. Our investigation has identified that the main mechanisms for influencing staff in the prison setting focus on training and the circulation of documents which tell and/or remind staff to do things in a certain way. We feel it's important to broaden this repertoire by drawing from some of the following behavioural change mechanisms and by driving change from the top downwards:

- Make task objectives clear and manageable; remove ambiguity
- Avoid adding to existing workloads
- Avoid goal conflicts, i.e. avoid tasking a member of staff to do one thing that, in the process, makes it more difficult for them to complete another task
- Make staff feel involved in the decision-making process
- Promote staff ownership and empowerment
- Utilise the power of peer pressure and the influence of norms
- Use the fact that individuals are more likely to take in and process information that is novel
- Recognise that people are more likely to change if they see this change as important or relevant to them
- Attend to how individuals feel about issues rather than resorting to rational argument alone
- Use praise and incentives
- Make judicious use of deterrents
- Promote consistency through role-modelling
- Create 'champions' for initiatives and pieces of work
- Promote a culture of transparency and the avoidance of blame
- Increase management visibility
- Connect staff with the outcomes of their work

The following recommendations draw from some of these mechanisms to help encourage change for the better.

RECOMMENDATIONS

Our recommendations are as follows:

1. At an organisational and cultural level, we recommend that further measures are taken to close the perceived gap between the main prison and the Healthcare unit at HMP Pentonville. This should help create a greater sense that HMP Pentonville is functioning as one organisation, comprised of staff and managers working together towards a common goal.

2. We recommend that at HMP Pentonville all temporary staff receive a prison induction before working in the prison for the first time. As well as covering safety and security issues, this induction should provide coverage of the ACCT Foundation training module (which has since been superseded by 'Introduction to Safer Custody') and the use of a wing's Observation Book. Alternatively, the onus should be placed on the agency/bank to provide only staff who have experience of working in prisons and who have received ACCT Foundation training in the recent past.
3. We recommend that HMP Pentonville's Healthcare unit keeps a log of temporary staff who have received a prison induction, whether they be booked through NHS Professionals or otherwise. We think it's important that this log is easily accessible and made visible to help promote ownership for the provision of these prison inductions.
4. Assuming that it's impractical for non-permanent clinical staff to attend an ACCT training course as permanent staff members do and long-term bank and agency nurses could, we recommend that a protocol be developed at HMP Pentonville to ensure that these staff are at least provided with a systematic ACCT briefing. This could be incorporated into a broader prison induction (see Chapter 13). We recommend that this protocol be developed in collaboration with Safer Custody.
5. (a) We recommend that a single system be introduced at HMP Pentonville that records who has received ACCT training and when the training took place. This system should cover both staff in the main prison and those working on the Healthcare unit. It should also cover both temporary and permanent staff. We suggest that the same system be used to monitor when refresher ACCT training is due.

(b) We recommend that a system-owner be assigned to ensure that action is taken, and that ongoing monitoring takes place. We suggest this owner should be the Safer Custody Senior Officer (SO). We also suggest that a member of staff in Healthcare is made responsible for liaising with the Safer Custody SO to provide this person with the information they need. We suggest that both individuals are involved in the design of the system to help promote clear ownership and to ensure the system is not perceived by users to be burdensome.
6. We recommend that part of the ACCT training (Foundation and Case Manager) should be modified by the Prison Service to convey an understanding of prisoner non-communication and how this should be interpreted, particularly when formulating risk assessments.
7. We recommend that the views of clinical staff with respect to ACCT are sought when they attend ACCT training at HMP Pentonville. By understanding in what regard ACCT is held, ACCT trainers will be better placed to explore with those attending how shared ownership of ACCT might be best promoted. We recommend that serious consideration should then be given to acting on the

outcomes of these discussions as a means of creating further buy-in for ACCT and of promoting shared ownership among discipline and clinical staff.

8. We recommend that HMP Pentonville's Healthcare unit takes steps to understand why ACCT triggers are not always given due consideration in prompting Case Conferences and documented discussions among staff. With this understanding, steps should be taken to improve the current situation. We recommend that any steps identified go beyond simply reminding or telling staff that triggers should be given consideration and that other mechanisms for changing behaviour are formulated and implemented.
9. To improve current audit trails, we recommend making it a requirement at HMP Pentonville that all staff print their name on the ACCT On-going Record rather than relying on initials or signatures to identify who has made each respective entry. We suggest that amendments are made to the prison's 'Guide to Management Checks of Open ACCTs' to reflect this change.
10. We recommend that existing mechanisms for ensuring that quality ACCT entries are made at HMP Pentonville be enhanced. This process may involve:
 - making the process easier for staff by OSRR providing guidance notes to accompany the ACCT document. These guidance notes should make explicit what is being looked for and not looked for, providing examples to help convey the key messages
 - praising individuals who are providing quality entries
 - utilising the power of peer pressure by making it public when good entries are being made
 - identifying deterrents against making poor quality entries
 - increasing staff's sense of involvement by providing a forum for individuals to talk about what using ACCT is like
 - connecting staff with the outcomes of their work, i.e. finding a way of demonstrating how quality ACCT entries have actually made a difference. This should help reinforce the idea that making quality entries really does matter rather than making entries because the 'process' demands it.
11. We recommend that HMP Pentonville moves away from the regime of hourly ACCT entries to help encourage the recording of more meaningful entries.
12. We recommend that HMP Pentonville's Healthcare unit reviews its use of 'Special Observation forms' and clarifies what value, if any, they are adding to the care and management of a prisoner who is on an observation regime.
13. (a) We recommend that more is done at HMP Pentonville to make it easier for staff conducting ACCT Case Reviews by clarifying for them what they are trying to achieve and how to fill in the form. We suggest this could be achieved by providing accompanying guidelines. Although it's in a different context, a good example of this approach can be found in the form of the Guidance Notes that

accompany the PER form (Person Escort Record form). These guidelines should provide greater clarity and promote greater consistency of approach.

(b) We also recommend that staff involvement is enhanced by seeking out their view about how well or otherwise the Case Reviews are working. There is an opportunity to disseminate this feedback to other prison staff and make ongoing changes to this element of the process. Encouraging involvement should also promote greater transparency and encourage individuals to challenge existing ways of doing things.

14. We recommend that some impetus be created at HMP Pentonville to ensure that the option of using discipline staff for one-to-one supervision is explored (see Chapter 13). Providing clear accountabilities and a timeframe for getting this piece of work done will go some way towards creating this impetus.

15. We recommend the ongoing use of the record-keeping audit tool being used on HMP Pentonville's Healthcare unit, whilst ensuring that it continues to make a tangible difference and informs decision-making, rather than being seen as a paper-filling exercise. Showing staff exactly how it is making a difference should further encourage its uptake, giving them a clear reason for doing what they have been asked to do.

16. (a) We recommend that guidelines be developed and implemented at HMP Pentonville as to what should and shouldn't be recorded in ACCT and SystmOne. These guidelines could be integrated into existing documentation. To make it easier for staff, we recommend that these guidelines include examples of what should and shouldn't be recorded. We suggest that an explicit acknowledgment is made that some overlap of information may be inevitable, but that it is important that discipline and clinical staff alike have as full a picture as possible of prisoners in their care.

(b) Before developing these guidelines, we suggest that work is done to understand both the clinical and discipline staff's perspective with respect to accessing what information they need. We suggest that consideration is made to making changes that don't increase the existing burden of work, but that do ensure that the 'right' information is recorded in the right place.

17. To make better use of pre-existing information, we recommend that psychiatric assessment guidelines used on HMP Pentonville's Healthcare unit reference the need to source and consider the results of medical and psychiatric assessments that may have been conducted by other institutions.

18. We recommend that at HMP Pentonville recently-made entries in the ACCT document, including triggers, are checked by a member of staff attending morning briefings so that any pertinent issues are identified and discussed in this forum.

19. We recommend that officers' attendance at ward rounds is embedded as a norm on HMP Pentonville's Healthcare unit, if this is not already the case. This should help further improve understanding and promote a sense of collegiate working among discipline and clinical staff.
20. We recommend that, as a matter of course, escort officers at HMP Pentonville are provided with a briefing as to the nature of the circumstances of the prisoner in their charge and what has been learned about that prisoner. This should provide further clarity for the escort officer as to what he/she is being tasked to do, and help to reduce levels of ambiguity and the risks associated with this.
21. We recommend that following serious incidents, measures are taken at HMP Pentonville to ensure that support is provided, and information is actively disseminated, beyond the day of the incident itself. Responsibility for how this support is provided and how information is disseminated should be agreed at the post-incident hot debrief so that respective responsibilities are clear, rather than hoping that individuals will take the initiative. This action should help to reinforce the message that the organisation cares about the welfare of its staff.
22. We recommend that steps are taken at HMP Pentonville to share findings of future internal investigations, whether these investigations are formal or otherwise, with the relevant audience(s). We would encourage the use of face-to-face fora for this, rather than simply circulating investigation reports. This approach should help enhance the feeling of staff involvement and would send a clear signal about how transparency is valued and promoted in the prison.
23. We recommend that efforts are made to ensure that representatives from Healthcare units across the Prison Estate meet on a regular basis. We feel that the key to making this a reality is ensuring that the agenda for such meetings is clear and agreed as a group. Meetings should then be perceived to be productive and therefore worthwhile attending. We suggest that a champion for this initiative be found from either inside or outside HMP Pentonville's Healthcare unit.

GLOSSARY

ACCT [i.e. ACCT Plan]	Assessment, Care in Custody and Teamwork: Care planning system used to help identify and care for prisoners at risk of suicide or self-harm
Association	Prisoners' recreation period / time out of cell
CAREMAP	Care and Management Plan, a part of the ACCT Plan
Category A	The category of prisoners whose escape would be highly dangerous to the public or the police or the security of the state, no matter how unlikely that escape might be, and for whom the aim must be to make escape impossible
Category B	The category of prisoners for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult
clinical staff	Healthcare professionals including doctors, nurses and Healthcare Assistants
constant supervision	Where a prisoner is under constant supervision by a member of staff who provides appropriate levels of support in order to reduce the risk of suicide or potentially fatal self-harm
CRB check	A Criminal Records Bureau check is a check of a person's details against criminal records and other sources, including the Police National Computer.
ECHR	European Convention on Human Rights
EMIS	Egton Medical Information System Limited. Known as EMIS, this is a primary care computer system used for patient records.
gated cell	A cell used for prisoners who require constant supervision. The cell has a gate instead of a full metal door, in order to provide the opportunity to observe and interact more closely with the prisoner.
GP	General Practitioner
Healthcare	HMP Pentonville's Healthcare unit
HMCIP	Her Majesty's Chief Inspector of Prisons

HMP	Her Majesty's Prison
hot debrief	The debriefing of staff involved in an incident as soon as practical after the incident has occurred
In-reach team	Department / Medical staff responsible for healthcare of prisoners suffering from mental health problems. This forms secondary mental healthcare in which prisoners are treated by specialists referred by primary care providers.
Listener	Prisoner volunteer who is selected, trained and supported by the Samaritans to listen in confidence to fellow prisoners who may be experiencing distress or despair
NHS	National Health Service
NMC	Nursing and Midwifery Council, the nursing and midwifery regulator
NOMS	National Offender Management Service, an executive agency of the Ministry of Justice
operational capacity	The operational capacity of a prison is the total number of prisoners that an establishment can hold, taking into account control, security and the proper operation of the planned regime.
Orderly Officer	Principal Officer responsible for ensuring the prison regime is running correctly. Responsible for the management of incidents
Oscar One	Radio call for the Orderly Officer
OSRR Group	Offender Safety, Rights and Responsibilities Group; part of NOMS
PER	Person Escort Record. Its purpose is ensuring that information about the risks posed by prisoners on external movement from prisons or movements within the criminal justice system is always available to those responsible for their custody.
PPO	The Prisons and Probation Ombudsman for England and Wales investigates complaints from prisoners, those on probation and those held in immigration removal centres. The Ombudsman also investigates all deaths that occur among prisoners, immigration detainees and the residents of probation hostels (Approved Premises)

PSI	Prison Service Instruction
PSO	Prison Service Order. A set of instructions issued by HM Prison Service to those responsible for the management and care of prisoners
Serco	Private security company operating prisons and prisoner transport services
SMT	Senior Management Team
SO	Senior Officer
SUI	Serious Untoward Incident. A term used in the National Health Service (NHS) to describe an accident or incident where the person suffers serious injury, major permanent harm or unexpected death
SystemOne	A clinical software brand supporting the 'one patient, one record' model of healthcare
video-link	Enables preliminary hearings at magistrates' courts to take place without the defendant being physically present, but with the defendant able to see, hear and participate in the process over a video-conferencing link

PART 1 - THE INVESTIGATION

CHAPTER 1. HOW WE CONDUCTED THE INVESTIGATION

Whilst leading the investigation, I was assisted by Kim Coulstock, a retired Prison Governor. A review of Mr Atlantic's clinical care was conducted by Dr Ian Cumming, Consultant Forensic Psychiatrist. Administrative support was provided by the PAs to Article 2 Investigators.

I shall make reference to 'we' throughout this report in acknowledgement and reflection of Mr Coulstock's and Dr Cumming's input to the investigation.

The terms of reference for the investigation are detailed in the Executive Summary.

We began our investigation by analysing various documents collated by the National Offender Management Service (NOMS). We judged which of these documents were relevant to the investigation. Copies of these documents are provided in this report's annexes, and include Mr Atlantic's ACCT document and medical records. After analysing these documents, we drew up a list of witnesses whom we proposed to interview.

Given the brief time Mr Atlantic was in HMP Pentonville prior to the incident (a little less than three days), we set out to talk to all those who had substantive contact with him from his time at Reception to the day of the incident. To provide additional context, we sought out copies of Mr Atlantic's police custody records and visited Forest Gate Police Station where he was in custody prior to his incarceration at HMP Pentonville.

Early in the investigation, we visited Mr Atlantic's solicitor, to whom we explained the terms of reference for the investigation and our desire to interview Mr Atlantic if he was so willing. We provided the solicitor with further updates as the investigation unfolded. We viewed the Healthcare unit where Mr Atlantic was located and the location of the incident on 24th August 2010.

All witnesses were given advance notification of their interview via written invitations. None of the witnesses whom we approached declined to be interviewed. Despite numerous efforts, we were unable to interview all healthcare staff involved in the constant supervision of Mr Atlantic. The Healthcare unit did not know the identities of some of these staff; they did know the identities of others but it was not possible locate these witnesses.

We conducted a total of 26 interviews. All interviews were conducted by Kim Coulstock and me jointly, and all were tape-recorded. Mr Atlantic was accompanied by his solicitor at his interview.

Reference to additional documents was made by witnesses during the course of some of the interviews we conducted. Where judged to be relevant, we sought out copies of

these documents and integrated the information into our investigation. An example was the Serious Untoward Incident (SUI) investigation report produced shortly after the incident in question.

All interviews were conducted at HMP Pentonville, some in Safer Custody in the main prison, the remainder in the Healthcare unit. Interviews took place between July 2011 and January 2012.

I met with Dr Cumming on completion of the first interviews to discuss the scope of his review of Mr Atlantic's clinical care. Dr Cumming was provided with copies of all interview transcripts, copies of the documentation we had amassed to date, as well as our initial findings. The findings from his own report have been incorporated into this report.

CHAPTER 2. HMP PENTONVILLE

HMP Pentonville is a Category B public prison and was opened in 1842. The numbers of prisoners held there is 1,228 (as at 22nd February 2011), with an operational capacity of 1,310.

PRISON STRUCTURE

HMP Pentonville is comprised of the main prison and the Healthcare unit. The main prison is divided into the following units:

- A Wing - Induction and First Night Centre
- B Wing - Resettlement wing for prisoners about to be released into the community
- C and G Wings - for remand and convicted prisoners
- D Wing - Enhanced Wing
- E Wing - providing continuous drug programme after the detoxification programme for prisoners
- F Wing - Substance Misuse Unit that offers a drug programme (detoxification) to support prisoners with substances misuse issues

The Healthcare In-Patient Unit is made up of the West Wing, East Wing and a central area.

PAST INSPECTIONS

In 2011, HM Chief Inspector of Prisons (HMCIP) acknowledged HMP Pentonville to be one of the most challenging local prisons in the country to run. A number of factors contributed to this finding. For example, it was reported that the prison “has a large and transient population drawn from some of London’s poorest boroughs, and its prisoners have amongst the highest incidence of mental ill-health and substance abuse of any local prison in the country.”⁷ Also, the age of the prison, its size and the nature of its population place limits on what can be modified and improved upon with respect to its fabric.

Other observations made by the HMCIP in 2011 included:

- Very busy reception, meaning staff are not able to attend to all immediate issues
- Similar pressures impacting first night and induction arrangements
- Four apparently self-inflicted deaths since the previous HMCIP inspection
- Impressive Healthcare unit

⁷ Report of an unannounced full follow-up inspection of HMP Pentonville, 24 February – 4 March 2011, by HM Chief Inspector of Prisons, p.5

At the last full HMCIP inspection (2009), the prison failed the 'healthy prison test' for the most vulnerable being held safely.⁸ The report of the HMCIP's follow-up inspection in 2011 found that, whilst some reasonable support was identified for those at risk of self-harm, the areas of assessment, care in custody and teamwork procedures were considered to be "underdeveloped".⁹ Some security measures were also judged to be "disproportionate".¹⁰

In the area of prison induction, prisoners reported feeling less safe relative to comparator prisons.

There had been four apparently self-inflicted deaths since the previous inspection. Some work had been done to consolidate recommendations from previous deaths and serious self-harm incidents, but concerns about response times to cell bells and effective monitoring checks had been a repeated theme. In the light of the four deaths, the inspection team concluded that ACCT procedures supporting at-risk prisoners were still not well-managed or fully focused-upon.

The inspection team concluded that Healthcare had conducted some good investigations into Serious Untoward Incidents (SUIs).

ACCT assessments were considered to be "good", and regular healthcare attendance at Case Reviews was reported. However, a recommendation was that Case Reviews and care plans for prisoners at risk of suicide and self-harm "be improved with consistent case management to ensure that identified needs are met".¹¹ Care plans were thought to place too much emphasis upon prisoners meeting targets. The following example was provided to highlight some of these problems, "One prisoner suffering from depression had tried to commit suicide at the time of his arrest and had not originally wanted to contact his family. Some weeks later, his care plan had a target for him to speak to his family, which he now wanted to do but he had been waiting three weeks for telephone credit to be arranged"¹²

In addressing previous concerns, the inspection team's expected outcome was more work to reduce the risks of self-harm and suicide through a whole-prison approach. Prisoners at risk of self-harm or suicide should be identified at an early stage, and a care and support plan drawn up, implemented and monitored. All staff should be aware of, and alert to, vulnerability issues, and be appropriately trained.

The last report also recommended that ACCT liaison officers should be appointed for each wing as an integral part of the suicide prevention strategy.

A recommendation was made in 2009 that the use of gated cells in the Healthcare unit should be monitored; that a protocol for their use should be agreed between the

⁸ Report of an announced inspection of HMP Pentonville, 11 – 15 May 2009, by HM Chief Inspector of Prisons, pages 9 and 10.

⁹ Report of an unannounced full follow-up inspection of HMP Pentonville, 24 February – 4 March 2011, by HM Chief Inspector of Prisons, p.10

¹⁰ Ibid, p.10

¹¹ Ibid, p.18

¹² Ibid, p.20

Healthcare unit and the Safer Custody function; and that this protocol should be implemented. This recommendation was repeated again in the 2011 inspection report.

During 2010 an average of 13 prisoners self-harmed each month and 44 ACCTs were opened. In the interviews we conducted as part of this investigation, staff reported that there would typically be 20 - 30 ACCTs open in the establishment at any one time; in Healthcare this may vary between 0 and 15.

HMCIP's inspection team reported that healthcare staff "attended ACCT reviews regularly but few others involved in the care of prisoners did so. Timings of observations in ACCTs were often too predictable and there were few quality entries indicating that officers had asked prisoners how they were feeling."¹³

Senior officers endorsed ACCT records with a daily stamp to confirm procedures had been followed. It was found, however, that this procedure rarely addressed the quality of interactions with prisoners.

ACCT training was provided monthly and was mainly aimed at case managers and ACCT assessors. Some new staff had received ACCT Foundation training but no programme of refresher training for staff trained several years ago was found to be in place.¹⁴

HMCIP's 2009 report identified that clinical records should be audited regularly to ensure that entries comply with professional guidelines. In response, a policy document focused on standards of record-keeping had been implemented in January 2011 and was due for review in April 2011. As a result of this policy, a 'Medical Records Audit' tool has been designed and implemented. Examples of tool entries and audit findings are provided in Annex 12.

The clinical lead nurses were responsible for checking clinical records in their respective area. EMIS was still used but SystemOne¹⁵ was due to be introduced in the following few months. It was reported that some clinical record-keeping remained unsatisfactory, with signatures and individual disciplines missing on some records. The new audit tool referred to above was designed to identify deficiencies and indicate where additional training was required. Issues and actions identified as a result of the November 2010 audit¹⁶ were as follows:

“How people use EMIS - the quality and consistencies of use of templates (including care plans and risk assessments), correct timing logged, and use of alerts for advanced directives was dependent on how familiar each user is with the EMIS System. As many of the users are “self-taught” or taught by others who were “self-taught” this has produced both inconsistencies and weaknesses in record keeping. However with the changes for System One

¹³ Ibid, p.39

¹⁴ Ibid, p.39

¹⁵ a clinical software brand supporting the 'one patient, one record' model of healthcare

¹⁶ See Annex 12: Medical Records Audit

[sic] this should be resolved with the agreed training plan for all staff and availability of user manuals prior to the system going live in February 2011.

Lack of consistency of quality of entries between different personnel. It is clear from this initial work that the directive around use of the NMC [Nursing and Midwifery Council] Code of Record keeping¹⁷ as their reference point for delivering quality standards of record keeping has not been sufficient. Both Inpatients and F Wing had copies of the guidance distributed last year yet many entries in the notes did not enable readers to have a sense of care or treatment delivered.

Action: The proposed supplementary record keeping guidance and audit tool is suggested for use across all clinical services. The need for improved quality in record-keeping will be an objective in all staff appraisals and there will be a clear expectation for the managers to audit with staff in their own supervision sessions. Improvement in the quality of record keeping is required across Healthcare services and management acknowledges the need to ensure all staff are trained to use System One [sic] correctly, be aware of expectations on them in completing electronic records and healthcare record-keeping guidance. Staff need to be fully aware that following the guidance and additional support that where poor quality record-keeping continues to be identified this will be addressed as a performance management issue initially as a supervision issue but if improvement does not occur as a capability issue.”

Issues and actions identified as a result of the February 2012 audit¹⁸ were as follows:

“How people use System One [sic] the quality and consistencies of use of templates (including care plans and risk assessments). Quality of SYSTEM One training has been an issue leading to most users continuing to teach themselves how to use the system.

Lack of consistency of quality of entries between different personnel. Whilst there is some clear examples of good work undertaken it is clear this is an ongoing area of need and management of staff members. Staff will be offered additional training from external trainers of SYSTEM One at end of March. New ward manager with a background in performance management has been tasked with establishing a local “how to use” guide. This is expected to be available in April 2012. Some issues are being addressed as individual staff capability and performance management issues through formal HR processes.

Action: Conclude further training. Agree templates post March training and development of “How to use guide” based on use of screen shots. Use of HR processes as appropriate for performance management.”

¹⁷ See Annex 14: Nursing and Midwifery Council. Record keeping. Guidance for nurses and midwives. Published in July 2009.

¹⁸ See Annex 12: Medical Records Audit

THE HEALTHCARE IN-PATIENT UNIT

The Healthcare In-Patient unit is a 22-bedded unit, made up of the West Wing, the East Wing and a central area. The West Wing comprises 10 single cells; the East Wing, 12 single cells. The Unit was opened in 2005.

Healthcare services are delivered via a consortium partnership of healthcare providers, including three local National Health Service (NHS) Trusts and the prison itself. The Trusts and their corresponding responsibilities are set out below:

- Whittington Health NHS Trust: lead contractor and provider of General Practitioner (GP) cover and primary care nurses, and the lead on first night processes
- Camden & Islington NHS Foundation Trust: lead for delivering nursing services on In-Patients, substance misuse services and mental health in-reach services
- Barnet, Enfield and Haringey NHS Mental Health Trust: provision of psychiatric input

At the time of the incident on 24th August 2010, Healthcare services were delivered by NHS Islington which subsequently became part of Whittington Health NHS Trust.

HEALTHCARE IN-PATIENT UNIT STAFFING

At the time of the incident on 24th August 2010, the Healthcare In-Patient Unit was staffed as described below:

- Service Manager
- Ward Manager
- Two Charge Nurses
- Six qualified nurses
- Two Healthcare Assistants
- Prison Officer team

The staff mentioned above reported to the Head of Healthcare via their Service Manager.

On a typical day, the unit would have four nursing staff on a day shift, which would be comprised of a minimum of two qualified nurses and two Healthcare Assistants, or three qualified nurses and one Healthcare Assistant. This would allow for two clinical staff per wing. After 17.30 hours, there would be two members of nursing staff on the unit, one for the East Wing and one for the West Wing.

A forensic psychiatrist worked Monday to Friday, seeing patients as and when needed, attending emergencies and supporting the in-reach team.

In terms of the number of discipline staff working in the Healthcare unit at the time of the incident, there were two Senior Officers (SOs) and 15 officers. The profile of officers per day was as follows:

- One officer on night duty
- One officer on evening duty (17.30 hours - 20.20 hours)
- One officer for the West Wing and two officers for the East Wing during the day

One additional officer was dedicated to the management of cleaners and the environment. On weekdays two additional officers were based off the Healthcare unit, managing the clinics.

Overnight, one officer and one nurse were on duty, plus any extra nurses or Healthcare Assistant detailed to undertake constant supervisions. The constant supervision shifts ran from 08.00 hours to 20.00 hours and from 20.00 hours to 08.00 hours.

RELEVANT HEALTHCARE UNIT PROCEDURES

In terms of procedures in the Healthcare unit, each morning there was a joint briefing between clinical and discipline staff. In attendance would be officers on duty, the Nursing Manager, nurses and other clinical staff (with the exception of doctors). At the briefing, night staff provided a handover about what had happened during the night, including details of any new admissions. At the daily briefing, the Senior Officer on duty would also detail his or her discipline staff. Also discussed would be any new Governor's Orders, instructions that needed to be given, details of any scheduled prison visits and of any scheduled court attendances.

With an important exception (given in the next paragraph), open ACCT records are kept in an office in each respective wing. At night-time ACCT records are moved to the Healthcare unit's central area. This enables the officer on duty to record events whilst doing his or her regular checks. At that time, in 2010, at the start of the morning shift officers working on each wing would collect their respective ACCT records from this central area, recording that they had done so. The ACCT records would then be reviewed by the officer on duty.

An exception to this rule is those prisoners who were on constant supervision; their ACCT documentation would stay with the constant supervision nurse at all times.

In the context of keeping staff informed, an Observation Book was also kept in one of the Healthcare unit offices. Nursing or prison staff were able to make entries in this book to record anything they were concerned about with respect to a prisoner and which they wanted to share with colleagues. The Observation Book could be consulted by members of staff who were coming onto a shift, so that they could understand what had been going on over a period of time. For example, the Observation Book might highlight certain members of staff who were being 'targeted' by a prisoner, and help members of staff prepare and protect themselves from the actions of particular prisoners.

PART 2 - THE BACKGROUND AND EVENTS IN DETAIL

CHAPTER 3. MR ATLANTIC'S BACKGROUND

Mr Atlantic was born in Russia in January 1968. He has been resident in the United Kingdom since August 2000 and holds a British passport.

He has no children. Prior to his wife's death, he had been divorced from her. He has no recorded next of kin and no family in the UK. He is a welder by profession.

Mr Atlantic's police record states that he was first remanded in custody in the UK in December 2008, having been arrested on suspicion of common assault and alleged to have pushed his then wife during a domestic incident. His wife reported the incident and Mr Atlantic was arrested later that day. He spent a night in custody and received a Simple Caution. This was the first time he was known to have been in police custody and he had no other known convictions at that time.

CHAPTER 4. MR ATLANTIC'S ARREST AND CARE BEFORE ARRIVING AT HMP PENTONVILLE

Mr Atlantic was arrested on 13th August 2010 at 2.12 am on suspicion of stabbing his ex-mother-in-law to death, and of slashing the throat of his ex-wife and stabbing her to death. We understand that these alleged crimes took place a few hours before Mr Atlantic's arrest.

Shortly after allegedly murdering his ex-wife and ex-mother-in-law, it is understood that Mr Atlantic allegedly set fire to the house in which he was taking refuge, and tried to kill himself by self-inflicted stab wounds to his neck, abdomen and both wrists. He was found by the Helicopter Emergency Medical Service in a smoke-filled room, believed to be in the family home.

Mr Atlantic was immediately taken to hospital for treatment to his injuries. He attended Accident and Emergency (A&E) at the Royal London Hospital (Barts and The London NHS Trust). He stayed within the Trust's care, receiving emergency surgery to his forearms and wrists at St Bartholomew's Hospital.

Mr Atlantic was recorded as being at a high risk of suicide.

Mr Atlantic was discharged from hospital on 19th August 2010 at 13.49 hours and taken to Forest Gate Police Station on 19th August 2010. Mr Atlantic arrived there at 15.15 hours with bandages to his wrists and throat.

During the Custody Officer Assessment¹⁹ (completed at 17.18 hours), when asked, Mr Atlantic stated that he was taking the following medication: ranitidine²⁰, diclofenac²¹, co-codamol²² and fluoxetine²³. He also stated that he wanted "out of here". Mr Atlantic was judged to be vulnerable and likely to try and kill himself if left alone. The instruction to physically supervise Mr Atlantic at all times was made.

At 18.00 hours, a solicitor was contacted and Mr Atlantic's details passed over by phone.

Mr Atlantic consented to a medical examination²⁴ at 18.18 hours. He presented to the Community Nurse Practitioner as coherent. His eye contact and body language were deemed to be good. Mr Atlantic did not appear to be withdrawn. He stated that he aimed to end his life when he inflicted wounds to himself.

The Community Nurse Practitioner concluded that Mr Atlantic should be on constant supervision and that medication should be dispensed by a healthcare professional as

¹⁹ See Annex 2: Police Custody Records

²⁰ Ranitidine is a medication used to treat and prevent ulcers in the stomach and intestines.

²¹ Diclofenac is an anti-inflammatory drug used to relieve pain and stiffness in arthritis and to hasten recovery following injury.

²² Co-codamol is an analgesic drug, i.e. a drug used to relieve pain.

²³ Fluoxetine is more commonly known as the anti-depressant Prozac.

²⁴ See Annex 2: Police Custody Records; Detained Person's Medical Form, 19/08/2010

required. Instructions were given that any concerns should be fed back to the healthcare professional.

Mr Atlantic was considered to be fit for interview, transfer and charge.

The medical examination concluded at 18.35 hours. At 19.12 hours, the solicitor attended the custody suite and was provided with a copy of the custody record. At 21.41 hours, continued detention was authorised.

A second medical examination was conducted at 23.45 hours. The Community Nurse Practitioner confirmed that Mr Atlantic had been prescribed medications by the hospital for self-inflicted injuries. The medications were checked and verified.

Mr Atlantic was given diclofenac sodium, co-codamol and ranitidine. Mr Atlantic requested sleeping tablets but his request was declined. Mr Atlantic was judged to be at high risk of self-harm and/or suicide and the recommendation was made that a constant supervision should be continued. The examination concluded at 23.55 hours.

At 08.43 hours on 20th August 2010, Mr Atlantic's solicitor again attended the custody suite. At 14.08 hours, Mr Atlantic was formally charged with the murders of his ex-wife and ex-mother-in-law on 12th August 2010. Bail was refused and Mr Atlantic was detained to appear at Stratford Magistrates' Court the next day.

A further medical examination took place at 17.00 hours on 20th August 2010. Mr Atlantic was given his prescribed medication and remained on constant supervision. The examination concluded at 17.05 hours.

At 08.42 hours on 21st August 2010, Mr Atlantic was transferred into the custody of Serco officers for escort and transfer to Stratford Magistrates' Court for appearance there at 09.30 hours.

The PER Risk Indicator²⁵ made reference to Mr Atlantic's criminal charge, his recent hospitalisation and the emergency surgery undertaken, and to his suicide attempt and self-inflicted cuts to his wrist and neck.

Stratford Magistrates' Court issued a warrant to Serco and the Governor of HMP Pentonville, stating that Mr Atlantic would be sent to the Central Criminal Court²⁶ on 24th August 2010. The order was given to hold Mr Atlantic in custody until produced at the Crown Court on the aforementioned date, and Mr Atlantic was remanded into custody at HMP Pentonville.

²⁵ See Annex 4: PER forms; Person Escort Record Form

²⁶ The Central Criminal Court is also known as the Old Bailey. It is also a Crown Court centre.

CHAPTER 5. MR ATLANTIC'S TIME AT HMP PENTONVILLE PRIOR TO THE INCIDENT OF SERIOUS SELF-HARM ON 24TH AUGUST 2010

SATURDAY 21ST AUGUST 2010

Those working on Reception at HMP Pentonville remember Mr Atlantic as arriving in their care with both arms bandaged. The prison would normally receive prior warning if someone had been on constant supervision before they arrived; however, it was unable to establish whether or not Mr Atlantic had been on constant supervision.

Serco provided a verbal handover to Reception staff at 14.35 hours. This handover included detail of the offences Mr Atlantic had been charged with. As well as a verbal handover, a completed PER²⁷ was provided. The information recorded included what time Mr Atlantic had been at court, details of his alleged offences, health risks pertaining to him, including the attempt on his own life, and the hospital treatment he had received, for Reception to then hand over to Healthcare staff.

At Reception, a note was made of Mr Atlantic's next court appearance as due to take place on 24th August 2010 at the Central Criminal Court. An 'Initial Referral Potential Category 'A' prisoner' form²⁸ was completed.

The following distinctive marks on Mr Atlantic were documented as follows:

- Slash/cut marks to throat
- Injury marks to stomach
- Slash/cut marks to both wrists/forearms

When interviewed, the Head of Healthcare stated that a Discharge Summary should have arrived with Mr Atlantic which would have covered an assessment of both his physical and mental condition, what his injuries were, what the course of treatment was going to be, whether there were any appointments for which he would have to return to hospital, and if any psychiatric assessment had begun.

The medication with which Mr Atlantic arrived at prison was taken from him in accordance with standard procedures.

At Reception, Mr Atlantic was observed by one of the officers as being uncommunicative, responding to questions with "No comment". Due to Mr Atlantic's lack of communication, the seriousness of his attempt to commit suicide and what Serco had communicated, the Reception Senior Officer asked an ACCT Assessor to speak to Mr Atlantic to try and get him to 'open up', in other words to find out how he was and how he was feeling. Before seeing Mr Atlantic, the officer was made aware of Mr Atlantic's alleged offence, but nothing more.

Mr Atlantic was taken by the officer to somewhere quiet to speak to. The officer used the time to try and understand if Mr Atlantic had prescribed medication for any mental

²⁷ See Annex 4: PER forms; Person Escort Record Form

²⁸ See Annex 3: Warrant documents

health issues, whether he had been in regular contact with a psychiatrist, and whether he felt he had anything to live for. Mr Atlantic refused to engage and answer any of the officer's questions. Most of the questions put to the officer were met with "No comment". The officer judged Mr Atlantic to be low in mood. Eye contact was poor. On the basis of what the officer had witnessed, she voiced her concerns and suggested to the Senior Officer that Mr Atlantic be assessed by Healthcare staff, and recognised a need for him to be monitored closely. This is in line with prisoner procedures for a prisoner deemed to be at high risk of suicide and/or self-harm.

On the basis of the aforementioned assessment information, the fact that Mr Atlantic had self-harmed before coming into custody, and concerns that he was going to do it again, the decision was made to open an ACCT. Witnesses whom we interviewed acknowledged that the decision to open an ACCT at Reception was unusual. An ACCT would more typically be opened only after a prisoner has been moved to the First Night Centre and interviewed by staff or seen by a healthcare professional.

The front page of the ACCT document²⁹ was completed by the Senior Officer working on Reception.

The officer who tried to engage with Mr Atlantic on Reception recorded "CRT 24/8/10" in the triggers section of the ACCT document, a reference to Mr Atlantic's impending Central Criminal Court appearance. This information was taken from Mr Atlantic's warrant of sending to Crown Court for trial.³⁰

The same officer completed the 'Concern and Keep Safe' form of the ACCT document.³¹ The following information was recorded on this form:

"Received from Court covered in bandages. Cuts to wrists and neck. Has been in hospital for 6 days. Tried to talk to him but he just responded saying 'No comment' to everything. Appears very low, would not make eye contact."

The Senior Officer completed the Immediate Action Plan, within the ACCT document, in respect of location and observations. It was also documented that due to his injuries, Mr Atlantic was unable to hold a telephone.

The officer and the Reception Senior Officer completed the Immediate Action Plan together and concluded that Mr Atlantic should be put on 30-minute observations until he had been assessed by Healthcare staff. This was noted on the ACCT document front cover. Witnesses informed us that these observations were at a more regular frequency than is typical for prisoners for whom an ACCT is opened immediately on arrival at HMP Pentonville; the more typical frequency was hourly until an ACCT assessment had been conducted, i.e. within 24 hours of the ACCT being opened. The reason given for the increased frequency was the nature of Mr Atlantic's injuries and

²⁹ See Annex 7: ACCT Plan 21/8/10 - 24/9/10

³⁰ See Annex 3: Warrant documents

³¹ See Annex 7: ACCT Plan 21/8/10 - 24/9/10

his recent suicide attempt. The officer in question was concerned about Mr Atlantic being left alone, and the associated risk of him attempting to take his own life again.

Mr Atlantic was given the option to speak to the Samaritans, whilst acknowledging that he was unable to hold the phone because of the injuries to his arms. He was offered a Listener but he refused the offer.

Mr Atlantic was then moved by officers, from Reception to A Wing (First Night Centre). In line with HMP Pentonville protocols, there was a desire to move Mr Atlantic out of Reception and into the First Night Centre as quickly as possible so that he could be cared for and monitored in a more effective way.

Mr Atlantic was seen by a Healthcare staff member who recorded on EMIS his charge, noted a depressed mood and thoughts of self-harm. She noted that an ACCT document had been opened. An initial Reception Health Screen³² was completed and Mr Atlantic was referred to the Reception doctor.

He was observed as making no eye contact, failing to engage in conversation, and low in mood.

Mr Atlantic was seen by a locum GP who, on the basis of his examination, put Mr Atlantic on a constant supervision regime. This was duly noted on the front cover of the ACCT document. The GP noted a depressive disorder. According to Mr Atlantic, the GP asked if he was in pain and whether he would like some sleeping tablets. Mr Atlantic said that he wanted both, and that he was in a lot of pain. Mr Atlantic was prescribed the following medication: ibuprofen³³ 400mg 24 TDS, zopiclone³⁴ 7.5mg NOCTE, fluoxetine³⁵ 20mg and ranitidine³⁶ 150mg. The GP recorded on EMIS that Mr Atlantic had requested painkillers and sleeping tablets. He also recorded the charge and that Mr Atlantic “refused to comment”.

Mr Atlantic then remained on A Wing and was placed with two Listeners.

Shortly afterwards, Mr Atlantic was escorted by an officer to the West Wing of the Healthcare unit and was received onto the unit at around 18.30. The Staff Nurse on duty that day was given advance warning of Mr Atlantic’s arrival. The Head of Healthcare advised the Charge Nurse that Mr Atlantic represented a high profile case, and for her and her team to be mindful of any media attention that the team and prison might attract.

It was recorded on EMIS that Mr Atlantic was to be nursed under constant supervision pending a review of his ACCT by the clinical team.

³² In the Reception Health Screen, the main screening tool used is the Grubin Assessment which was developed by Professor Don Grubin. Developed in 2003, it focuses on a number of physical health, medication and mental health parameters, and is now the main Reception health screening tool used across the Prison Estate.

³³ Ibuprofen or Brufen is a commonly used, non-steroidal, anti-inflammatory medication.

³⁴ Zopiclone is a first-line hypnotic or sleeping tablet medication. Nocte means at night.

³⁵ Fluoxetine is more commonly known as the anti-depressant Prozac.

³⁶ Ranitidine is a medication used to treat and prevent ulcers in the stomach and intestines.

Mr Atlantic was searched by a Healthcare Officer and a Staff Nurse to ensure there was nothing on him that could be used to commit an act of self-harm. The cell was also checked for anything that might be used to self-harm. He was put into a gated cell, and continued on constant supervision, with the Staff Nurse located outside the cell by the gate.

When interviewed, Mr Atlantic remembered asking for his medication and that he wasn't given any until Monday 23rd August. This is at odds with what is documented and recalled by witnesses. For example, there are entries stating that he was "compliant with his prescribed medication"³⁷ and elsewhere that he was taking medication.

A Brief Risk Assessment (Form CPA6)³⁸ was completed in the Healthcare unit by one of the Charge Nurses using documented information furnished to her. The following information was recorded under Risk Assessment:

- History of violence: "two incidents"
- History of suicide attempts: "one"

It was noted that Mr Atlantic was on remand and his alleged offences were stated. It was also noted that on 12th August 2010 he had made serious self-harm attempts and had set fire to his flat.

Further action recommended extended to a discussion with the multi-disciplinary team, assessment by a specialist team, and for assessment to be continued.

The following risk management plan was recorded:

"Observation level to be reviewed as required. Currently being nursed on constant observation level and maintained on Hourly ACCT. Psychiatrist and GP to facilitate regular review of mental states and physical health. Staff to offer support through regular 1-1 and facilitate holistic needs"

A nursing care plan was also completed and detailed the following:

- Patient presents a risk to self.
- "Patient made serious self-harm attempts on the 12th August 2010. He self-inflicted deep injuries in both forearms, abdomen and neck"
- "Patient committed two murders prior to the serious self-harm attempts"

At the end of her shift, a previously booked bank nurse took over constant supervision duties. The bank nurse was provided with a verbal handover from the Staff Nurse and was asked to read through Mr Atlantic's ACCT document.

³⁷ See Annex 6: Medical reports and records; in Registration Details 22/08/2010 at 15.29

³⁸ See Annex 6: Medical reports and records

The Staff Nurse was informed in advance that Mr Atlantic was unable to feed himself or use the toilet, although her recollection is that, despite his bandaged hands, Mr Atlantic was able to feed himself. Given that there are later accounts of Mr Atlantic feeling or being unable to feed himself, and her reference to fetching a spoon, rather than a knife or fork, we assume from this that the food in this instance did not need cutting.

Mr Atlantic was observed as sleeping intermittently through his first night, occasionally getting up to use the toilet and to request drinking water.

The constant supervision was carried out by a mix of bank nurses and permanent staff working a 12-hour shift, with a 5 - 10 minute break offered every 60 - 75 minutes, plus an extended break of one hour during the course of the shift. This is standard procedure within the Healthcare unit. The intention would be to try and use permanent staff to carry out one-to-one supervision as that person is more likely to be familiar with the prison in question and the work itself. On a day shift, it is sometimes possible to have one of the four nurses working to undertake a constant supervision shift although this is dependent on other factors such as whether or not a ward round is scheduled.

Witnesses confirmed that if it's not possible to resource the constant supervision resource from amongst permanent staff, healthcare resources would be sought from the Camden and Islington bank. Should no suitable resources be available through this route, No. 1 Recruitment Services, specialists in the provision of nursing and healthcare professionals, would be contacted. One of the Healthcare managers told us that one of the attractions of using the latter organisation is that most of the agency staff enrolled have prison security clearance.

At the time of writing, we can confirm that the National Health Service stipulates minimum criteria that recruitment agencies must meet before being able to offer staff to the NHS. The No. 1 Recruitment Agency requires that all nurses and Healthcare Assistants in its employment must be fully NHS-compliant in order to be registered with the agency. This compliance includes the provision of two clinical references, a CRB check³⁹, clearance by NHS Occupational Health and the right to work in the United Kingdom. All mandatory training must have been completed within the last 12 months. All qualified staff need to provide proof of qualification as well as proof of Nursing and Midwifery Council (NMC) registration. Prison information handbooks are given to agency workers going into prisons.

Since the incident of serious self-harm on 24th August 2010, agency staff who had formerly been booked from the No. 1 Recruitment Agency, in order to cover shifts to fill gaps in rotas for permanently contracted Camden and Islington NHS Foundation Trust staff, have been transferred to employment by NHS Professionals under Transfer of Undertakings Protection of Employment (TUPE) regulations.

³⁹ A Criminal Records Bureau check is a check of a person's details against criminal records and other sources, including the Police National Computer.

Although we have requested the information, NHS Professionals has not provided us with the minimum criteria for nurses and Healthcare Assistants to be registered with this body.

When booking clinical staff from either the bank or the agency, the ideal profile being sought by the Healthcare unit at HMP Pentonville is as follows:

- Has mental Health background
- Is Band 2 or 3 Health Care Assistant (who generally hold an NVQ⁴⁰ in Health and Social Care)
- Has previous experience of having worked at HMP Pentonville
- Is security-cleared to work in HM Prisons
- Has experience of conducting constant supervisions

In reality, these clinical staff will have experience of mental health issues, but may not have had experience of working in a prison setting, and may not have obtained full prison security clearance. Most of the staff booked through this route will have had experience of conducting constant supervisions in the psychiatric system, whether in the community or in a prison setting.

We were led to believe that HMP Pentonville's Healthcare unit has a list of bank and agency staff who have been booked on a regular basis. The unit prefers to use this list to help ensure that those booked have at least some experience of working in a prison setting. However, some doubt has been cast over whether such a list exists; during the course of this investigation there was considerable difficulty in identifying who was actually employed for a given constant supervision shift.

Whilst there is a desire to rotate permanent staff into constant supervision duties as would typically happen on an open ward, the logistics associated with this are deemed to make it impractical. The principal barrier is the delay in the process of obtaining security clearance for these staff. Security clearance is required before staff are permitted to carry security keys.

Healthcare staff booked through the bank or agency do not receive formal training in the use of ACCT. The expectation is that they will have at least received an informal ACCT briefing; however, at the time of the incident of serious self-harm, no protocol had been developed for this, and no records had been kept of who had been briefed and who had not.

The expectation was that a senior nurse would provide this ACCT briefing at the start of a shift for those who needed it and that the briefing would cover what documents should be completed, and guidelines on how this should be done.

When interviewed, Healthcare management acknowledged the limitations of using bank and agency nurses. These limitations include the lack of continuity of care and therefore limits on building up a meaningful yet bounded relationships with prisoners. As one manager said, "Ideally, I wouldn't source anybody through either

⁴⁰ National Vocational Qualification

[the bank or agency].” “The challenges are that you don’t know the individual; you don’t know what their range of competencies ...” “We do have scenarios ... where we’ll have someone for a shift, and we’ll say, ‘That person’s not coming back.’”

We were told that, when sourcing clinical staff through the bank, this information would be recorded on the nurse’s file and passed on to the next potential employer. With the agency, we were led to believe that no such mechanism was in place.

To help address some of the issues described above, HMP Pentonville non-permanent clinical staff are asked to register with NHS Professionals.

During the course of our interviews, it emerged that efforts were being made to use officers for one-to-one supervision in place of bank and agency staff. Work had been done towards achieving this since May 2011, but no clear statement of how much progress had been made towards this end was available. As one Healthcare manager admitted, “I haven’t been...able to move as far with [this] as I’d like to”. It was acknowledged by the manager that this would help reinforce the sense of an integrated team in the Healthcare unit. One option being put forward was to have a pool of officers that could be used by Healthcare, and re-charge applied to reflect the shared use of resources from budgetary perspective.

SUNDAY 22ND AUGUST 2010

On Sunday 22nd August 2010, there was a morning handover from the night-shift staff at around 9 am. At the handover, it was reported that Mr Atlantic wasn’t happy with his medication, and that he wanted the same pain-relief medication, for example co-codamol, that he had been receiving when in hospital. This is corroborated by Mr Atlantic who recalls making staff aware that he was in pain, and that he had asked for medication to help ease this pain.

When interviewed, the Charge Nurse explained that it was standard practice for locum GPs to avoid prescribing strong painkillers such as co-codamol and tramadol⁴¹, substituting these for weaker analgesics such as ibuprofen or paracetamol until, or unless, the ward doctor increased painkiller strength if they deemed it necessary. This practice was verified by the clinical reviewer to this investigation and is driven by the high level of drug and alcohol misuse in the prison population. This, in turn, results in some caution in prescribing powerful analgesics to prisoners for fear of these being misused or diverted to other prisoners.

Although there was no recollection of what took place during that particular morning, normal procedure would be to hold a morning briefing to go through who was on constant supervision, how many ACCTs were open, how many prisoners were on the unit, and who was on a ‘restricted unlock’ as a result of their behaviour.

⁴¹ Tramadol is an opioid, i.e. narcotic, drug used to relieve severe pain following a heart attack, surgery or serious illness

As Mr Atlantic was in obvious pain and had restricted movement of his hands, the Charge Nurse helped Mr Atlantic with his food, cutting it up and feeding him.

During the morning of the 22nd August 2010, Mr Atlantic slept intermittently.

At 2 pm Mr Atlantic was asked by one of the officers if he minded him carrying out an ACCT assessment. The procedure was explained to him. Mr Atlantic did not answer any of the ACCT assessment questions, stating that he did not want to discuss anything. He was asked why that was the case, but declined to answer. He responded to each question with “No comments”. His responses were recorded on the ACCT document⁴².

At 2.30 pm one of the Senior Officers attempted to engage with Mr Atlantic with a view to him participating in the first ACCT Case Review. Mr Atlantic said he didn’t want to talk and he was adamant about not wanting to participate. He was offered a television or a radio, which he declined, and he was asked if there is anything else he wanted. Mr Atlantic does not remember being offered a television or radio.

The first ACCT Case Review was conducted and attended by a Staff Nurse, a Senior Officer and an officer. The SO added “Being left unsupervised” as a trigger in Mr Atlantic’s ACCT document. When questioned, the SO explained to us that his judgement was influenced by that fact that even though Mr Atlantic’s arms were incapacitated, there remained a risk that he could find some method of harming himself if left on his own.

The presenting level of risk was documented as “high”. The recent serious self-harm incident was a factor in categorising Mr Atlantic’s level of risk in this way; other factors were the fact that he was on constant supervision and his general lack of willingness to engage with staff.

The CAREMAP was completed by the same Senior Officer immediately following the first Case Review. The following information was recorded in the CAREMAP:

- Issues: “Refusing to engage with staff”
- Goals: “gain trust by offering support”
- Action required: “staff interaction”
- By whom and when: “All staff”

At 14.40 pm it was documented that Mr Atlantic “remains largely ambivalent to talk. His speech remains monosyllabic, only responds to questions in a minimal manner.”⁴³

At 15.29 pm it was documented that Mr Atlantic “appears withdrawn and subdued in his presentation. ... [He] has not expressed any morbid thoughts or ideas of self-harm”.⁴⁴

⁴² See Annex 7: ACCT Plan 21/8/10 – 24/9/10

⁴³ See Annex 6: Medical reports and records; in Registration Details, in an entry in the Medical Record

⁴⁴ See Annex 6: Medical reports and records; in Registration Details, entry in the Medical Record

Throughout the afternoon and evening of the 22nd August 2010, Mr Atlantic lay on his bed and appeared to be sleeping intermittently. He continued to eat his meals, take his medication, and use the toilet.

Mr Atlantic was observed as sleeping through the night.

MONDAY 23RD AUGUST 2010

On Monday 23rd August 2010, there was morning handover from the night-shift staff. At 9 am Mr Atlantic was offered medication but he declined it. During his interview with us for this Investigation, Mr Atlantic recalled that this medication did not help ease the pain he was experiencing.

The Charge Nurse had previously requested that the forensic psychiatrist attend Mr Atlantic on this day. This was in accordance with normal procedure to see a prisoner as soon as possible after arrival on the unit and to ascertain whether Mr Atlantic should continue on a constant supervision regime. The psychiatrist was given a verbal handover at around 11 am by one of the nurses, during which he was told that Mr Atlantic wasn't talking or doing very much at all.

The forensic psychiatrist was also aware that Mr Atlantic had allegedly committed a serious crime. The psychiatrist could see that Mr Atlantic was breathing regularly and therefore had no concern for his physical health. As it was unclear whether or not Mr Atlantic was sleeping, the psychiatrist decided to return later in the day rather than potentially waking Mr Atlantic up and jeopardizing the possibility of a productive encounter.

The forensic psychiatrist returned at around 2.30 pm. Mr Atlantic was awake. He told the psychiatrist that he spoke Russian and English, and that he was willing to talk to the psychiatrist but that he was tired. He therefore asked that the psychiatrist return the following day.

The forensic psychiatrist was not therefore able to conduct an objective, psychiatric assessment at that time. However, on the basis of Mr Atlantic's demeanour, brief interaction, ability to understand English, and limited communication with others, the psychiatrist considered him to present a risk to himself, and so recommended that the one-to-one observation regime continue, pending a further review. He considered that Mr Atlantic might still be in shock and still be determined to end his own life. The psychiatrist also decided to stop Mr Atlantic's anti-depressant medication with a view to examining him medication-free at a later date. The psychiatrist's view was that without the 'clouding' effects of the medication, a clearer picture could be gained of Mr Atlantic within a week or two. As Mr Atlantic was in a place of safety, the psychiatrist concluded that there was time to review his mental health.

At around 3.30 pm, the locum GP visited Mr Atlantic as part of his ward round. He recorded that Mr Atlantic had nothing to say and had no complaints.

Later in the afternoon, Healthcare staff were informed that Mr Atlantic had been categorised as a Potential Category A (Pot. Cat. A) prisoner and that staff were not to approach Mr Atlantic without an officer being present. Staff were informed that Mr Atlantic should wear E-List clothing⁴⁵ when out of this cell. Mr Atlantic was given E-List clothing to wear to check that it fitted him, but it was documented by officers that he refused to wear it. When interviewed as part of this investigation, Mr Atlantic recalls that an officer pointed at him at this time and shouted that he was a murderer. His recollection is that he did actually wear the E-List clothing. We have been unable to corroborate either of these facts.

After about an hour, Mr Atlantic's name was removed from the Potential Category A list. When interviewed, Mr Atlantic recalled that he was told he couldn't wear the E-list clothing at night and that he was left to sleep in his underpants with a small blanket. He recalled being very cold during the night.

At 6 pm, Mr Atlantic was approached to participate in a second ACCT Case Review. He presented as calm but refused to engage with members of the review team. When asked about his mood and thoughts, he replied, "No comments". He did, however, speak about his needs, such as wanting an extra breakfast pack. Also documented was the fact that Mr Atlantic made good eye contact and was coherent. The team concluded that Mr Atlantic "remains unpredictable and guarded". It was acknowledged that given the limited level of engagement with Mr Atlantic, there was much unknown and left to explore before a decision could be reached as to whether or not to take him off constant supervision.

The level of risk was reviewed and lowered from "High" to "Raised". When trying to understand why the level of risk was lowered, the case manager explained that for her "'raised' is just similar like 'high'".

Mr Atlantic spent the rest of the evening and night lying on his bed, getting up to wash, taking his medication, and using the toilet. On occasion during the night, he challenged the constant supervision nurse as to why she was shining a torch at him.

When interviewed as part of this investigation, Mr Atlantic recalls that the torch was shone in his eyes on a regular basis at night, and that this bothered him. He also recalls not being given a pillow or linen, only blankets. He recalls being told such items weren't allowed and that he felt cold during the night. He also recalls being annoyed by one staff member who refused to give him some privacy to use the toilet. He remembers this as being "embarrassing and degrading" for him.

During this period of a little less than three days in Healthcare (21st – 24th August 2010), Mr Atlantic's level of engagement with staff was variable. At times he refused to talk when attempts were made to engage with him; at other times he did speak to staff. He was selective as to who he communicated with. He disclosed where he came from, what his job was, but at no point made reference to the events that took place leading up to his arrest. Conversations were typically restricted to Mr Atlantic talking about his needs, for example, help with opening milk cartons and sachets of sugar,

⁴⁵ E-list clothing indicates that a prisoner is on the Escape List (E-List).

with no reference to his feelings or mood. Often his communication was monosyllabic, without elaboration of answers to questions put to him by staff such as, "How do you feel?"

Although attempts were made, a number of members of staff were unable to build what they would describe as a rapport with Mr Atlantic. The nature of the interaction was more transactional in nature, particularly with female members of staff, with communication focused upon meeting his needs and no more. In contrast to this, one officer feels he was able to build up what he described as a 'level of trust' with Mr Atlantic.

Mr Atlantic's eye contact with members of staff was generally good. He was coherent and his cognition was judged to be good.

His appetite was considered to be consistently good.

Throughout this same period, Mr Atlantic's mood was also observed as variable. At times, he presented as angry, swearing at members of Healthcare staff; at other times, he was observed as quiet and subdued, with 'flat' affect but not depressed.

At times, Mr Atlantic declined to take his prescribed medication. No reasons were given as to why.

Mr Atlantic was generally reluctant to receive care from nursing staff, wanting to do things for himself. This extended to his eating and personal hygiene, for example, teeth-brushing. One member of staff described him as "very proud" in his way of being. His level of personal hygiene was observed to be good.

When interviewed as part of this investigation, Mr Atlantic recalls sleeping poorly during his time on the Healthcare unit and attributes this to the level of pain he was experiencing at the time. His recollection of being on the Healthcare unit was of being "depressed" and "in pain". He can't recall whether he didn't want to speak to staff or whether he "couldn't manage" to speak to staff because of the pain he was experiencing. He remembers that "the three days here were a nightmare for me. For three days I was not washed or cleaned in any way. I couldn't do it myself due to my injuries and no-one did it for me".

At no point during this period did Mr Atlantic leave his cell.

CHAPTER 6. THE DAY OF THE INCIDENT OF SERIOUS SELF-HARM

On 24th August 2010 a morning handover took place in the Healthcare unit. As normal, this took the form of a joint briefing involving clinical and discipline staff.

The constant supervision Healthcare Assistant [HCA] was sourced from the bank and arrived for her shift at 8.00 am. She had been informed by telephone beforehand that she would be conducting a constant supervision shift. She stated that she had been working shifts at HMP Pentonville for approximately 18 months. On arrival for her shift, the constant supervision HCA was informed why Mr Atlantic was in custody, and that he had tried to kill himself. She was also given a verbal handover from the constant supervision nurse coming off shift. The latter reported no unusual behaviour during the course of the night.

At the beginning of her shift, the constant supervision HCA introduced herself to Mr Atlantic and checked whether he needed anything. She recalled that Mr Atlantic did not acknowledge her.

Mr Atlantic had originally been scheduled to appear in person at the Old Bailey that day and then to be transferred on to HMP Belmarsh; however, that arrangement changed the previous day from a personal appearance in court to a video-link appearance. We have been unable to ascertain why this change of arrangement was made.

The constant supervision HCA had never accompanied a prisoner to video-link before, and she did not know the video-link route. It was explained to her that she wouldn't actually enter the video-link room, but that she would have to observe and record whatever was going on between Mr Atlantic and whoever he was communicating with at the other end of the video-link.

The Senior Officer on duty also received and read a handover email from his colleague who had been on duty for the period from 21st – 23rd August 2010. The SO on duty on the 24th August 2010 doesn't recall the email containing anything unusual. This indicated to him that Mr Atlantic must have had a "quiet night".

Mr Atlantic's video-link court appearance was scheduled for that morning. At the morning debrief, no witnesses recall mention of this court appearance, or of the trigger noted in his ACCT document.

The prison officer detailed to escort Mr Atlantic to the video-link visited the Healthcare unit between 8.00 am and 8.30 am to see if Mr Atlantic was fit, able and willing to attend court. The officer wouldn't normally have done this but he had been unable to contact the Healthcare unit by telephone to check if Mr Atlantic was fit for attending court via video-link. En route to the Healthcare unit, the video-link officer bumped into the Senior Officer working in Healthcare, who stated that Mr Atlantic was fit for court. However, the video-link officer wanted to verify this for himself, and proceeded to the Healthcare unit to see Mr Atlantic in person.

Before arriving at the Healthcare unit, the video-link officer was unaware that Mr Atlantic was on constant supervision. With the ward officer present, the nature of the video-link was explained to Mr Atlantic. When interviewed, Mr Atlantic acknowledged that he didn't know what a video-link was at this point. Mr Atlantic enquired which court he was appearing in and this was confirmed as the Old Bailey but that his actual 'appearance' would take place inside the prison. Mr Atlantic confirmed that he was fit and willing to attend. He did not enquire as to where the video-link was, nor was any part of the route that would be taken to reach video-link explained to him.

Mr Atlantic's frame of mind was considered to be "all right" by the video-link officer. The officer then left the unit and returned to the video-link, saying he would be back to collect Mr Atlantic at 10.30 am.

Mr Atlantic then put on some clean clothes, had a shave and prepared himself for the video-link appearance. The constant supervision nurse observed Mr Atlantic to be "calm".

The video-link officer returned at approximately 10.30 am to escort Mr Atlantic to the video-link. One of the Healthcare Officers offered on two occasions to accompany the video-link officer, on the basis that he knew Mr Atlantic and had struck up a level of rapport with him. The video-link officer declined the offer.

The video-link officer was informed that the constant supervision HCA would be accompanying him. Before leaving, Mr Atlantic asked to see the Healthcare Officer who had offered to accompany him to the video-link. Mr Atlantic thanked him and said goodbye. Mr Atlantic, the video-link officer and constant supervision HCA left the ward through the ward door and security door. Mr Atlantic was escorted across the landing, to another door that leads on to a corridor, stairwell, and first floor landing. This door was unlocked by the officer. The HCA, and then Mr Atlantic passed through this door, followed by the officer. The HCA and Mr Atlantic stood together by the stairwell railing as the officer turned to lock the door behind him. As the officer turned to lock the door, Mr Atlantic dived over the railing head first, on to the stairwell below, without the use of his hands or arms. Mr Atlantic doesn't recall having any prior knowledge of the stairwell. We have been unable to ascertain whether or not he had entered the Healthcare unit by the route in question.

On witnessing this, the HCA shouted, "Officer! Officer!" The officer ran to the railings to see what had happened. On seeing Mr Atlantic lying on the stairs below, the officer opened the door he was in the process of locking, and told the HCA to get some help. In the meantime, the video-link officer stayed with Mr Atlantic.

The HCA ran into the central area of the Healthcare unit and banged on the door to the West Wing shouting, "Officer, Officer, Officer". One of the Healthcare Officers went over to the HCA and asked what had happened. The HCA replied, "He's done a runner, he's done a runner." The officer ran to the scene of the incident. He found one of the

Healthcare SOs already at the scene. The officer put through two Hotel 9 Level 1 calls.⁴⁶

The Senior Officer who was the first to attend the incident saw Mr Atlantic lying at the bottom of the stairs. He was lying face down with his arms above his head and his head turned to the side. His head was near the bottom of the stairs with his legs going up the stairs. The SO noticed that there was a lump on Mr Atlantic's back, to the right of his spine, that his head had split open, and that he was bleeding from this wound.

He decided that his main priority was to stabilise Mr Atlantic's head which is what he did. He could see that Mr Atlantic was in pain, and was making a noise. He tried speaking to him to get a response, telling him to "keep still". Although Mr's Atlantic's face was against the wall, the officer noticed that the area around his temple was twitching. As he held his head, other colleagues attended, including the nurse practitioner, who was holding the Hotel 9 radio. Further attempts were made to talk to Mr Atlantic.

As instructed by the nurse practitioner, the Orderly Officer called an ambulance which arrived within a few minutes.

The nurse practitioner took charge of the incident from a clinical perspective. This included co-ordinating the team that was there to ensure that Mr Atlantic was managed appropriately. The Nurse Practitioner quickly obtained a history and learned that Mr Atlantic had jumped over the railings and fallen onto the stairwell.

The nurse practitioner established that Mr Atlantic had probably hit his back and then rolled over onto his front. She was particularly concerned about spinal injuries, particularly after noting the swelling on Mr Atlantic's back, and she saw her main priority as immobilizing Mr Atlantic.

When the nurse practitioner spoke to Mr Atlantic, he responded to her but only by mumbling.

Treatment revolved around making sure Mr Atlantic's airway was open, that he wasn't losing consciousness, that his blood pressure was maintaining his circulation, and that his C-spine⁴⁷ and thoracic spine⁴⁸ were immobilised.

The nurse practitioner requested a neck brace. A Hotel 9 bag⁴⁹ was duly brought by one of the Staff Nurses. The neck brace from the bag was put on Mr Atlantic.

The ambulance personnel then led on moving Mr Atlantic down from the stairs onto the flat surface, and he was then put onto a spine board.

⁴⁶ 'Hotel 9' indicates a medical response needed; 'Level 1' call indicates a serious incident.

⁴⁷ cervical spine, comprising the top seven vertebrae of the spine

⁴⁸ The thoracic spine is located below the cervical spine and comprises 12 thoracic vertebrae.

⁴⁹ an emergency bag containing emergency equipment, including a neck brace

The Duty Governor also attended the scene. She satisfied herself that the incident was being dealt with from a clinical perspective. She also recognised that the situation was contained and controlled that there would therefore be no further impact on the rest of the establishment.

Also attending the scene were a second officer, a Staff Nurse and a specialist nurse practitioner. The specialist nurse practitioner saw her role as being present if the nurse practitioner needed anything.

The Staff Nurse attended to support the primary care team, including being available to bring them anything they wanted.

In the meantime, the Safer Custody Manager was made aware of the incident and attended the Healthcare unit. Once he had assessed the situation, and it was clear to him that Mr Atlantic was going to be admitted to hospital and that his medical care was in hand, he contacted Security. The Safer Custody Manager considered the strength of the escort and recommended that three staff accompany Mr Atlantic. The normal escort would be two officers. His decision to recommend a larger escort was influenced by his knowledge of Mr Atlantic's alleged offence. At this time, he was unaware of the nature of Mr Atlantic's injuries.

The ambulance transported Mr Atlantic to the Accident and Emergency Department of the Whittington Hospital. Staff accompanied him en route to hospital. The Duty Governor collected keys from those members of staff who were accompanying Mr Atlantic to hospital.

Once the ambulance had left, the nurse practitioner documented on the patient's notes what had happened.

In line with her responsibilities, the Duty Governor then held a hot debrief in one of the rest rooms. This debrief was used:

- to check the welfare of staff attending the incident
- to offer support and encouragement to staff
- to offer access to the Care Team

We have been unable to establish whether the debrief was also used:

- to establish that everything that could have been done was done
- to give staff an opportunity to reflect
- to provide staff with an opportunity to express what they did and did not understand about what went on in the incident in a safe environment
- to establish if there was anything to be learned from what went on

Those witnesses interviewed recalled the immediate impact the incident had on staff. One observed: "The staff that attended ... were very shook up ... it was quite shocking what he did to himself."

Some of those who had attended the incident were not aware of a debrief, or of their need to go to one. In hindsight, those individuals felt they would have benefited from attending, to better understand what went on.

The escort officer and constant supervision HCA were asked to make a written statement. We have been unable to source a written statement made by the HCA. The escort officer statement was made on 'HMP Pentonville Incident Form B – Staff Report'⁵⁰. The video-link officer has since confirmed that, whilst other routes could be taken from Healthcare to the video-link, the route described is the one he would typically take and that he had taken for the previous two years.

Both members of staff were asked whether they wanted to stay or to go home. The HCA opted to go home. The video-link officer chose to carry on working.

Given the nature of Mr Atlantic's actions and his fall onto a hard surface, the HCA assumed that Mr Atlantic had died.

The incident was recorded on the Incident Report System which automatically passes through to the National Offender Management Service (NOMS) for processing. An 'HMP Pentonville Incident Form A – Managers Report' was completed by the Orderly Officer⁵¹.

A 'Self-harm / attempted suicide (F213SH)' form was also completed⁵².

The 'Medical Officer's report' recorded the following:

"Mr Atlantic self-harmed by diving/jumping from stairwell from Inpatients Unit Healthcare. Initial on scene examination by Nurse ... revealed a 6cm gash on back of head. C-Spine precautions were employed. Paramedics attended and patient moved to A&E Department. Full report by Nurse ... on EMIS."⁵³

A 'Serious Self-harm Incidents Questionnaire' was also completed by the Safer Custody Manager.⁵⁴

When interviewed as part of this investigation, Mr Atlantic expressed some surprise that he had not been held by the arm or by his belt/trousers as he was being escorted. He reported previous experiences of being escorted from the police station to a court hearing with an officer behind him, one in front, and one on either side of him.

Mr Atlantic stated that he had not planned beforehand to jump.

⁵⁰ See Annex 10: Completed Incident Forms

⁵¹ Ibid

⁵² See Annex 6: Medical reports and records

⁵³ Ibid

⁵⁴ See Annex 10: Completed Incident Forms

CHAPTER 7. 24TH AUGUST 2010 AND BEYOND

Mr Atlantic was admitted into hospital on 24th August 2010 and assessed. Standard bed-watch processes were then followed.

Due to the severity of his injuries, Mr Atlantic was transferred from the Whittington Hospital to the Royal London Hospital. His injuries were confirmed to be unstable fractures of C5 and T11⁵⁵ which were encroaching on his spinal cord. As a result of these injuries, he is now paralysed below his chest. He does have movement in both arms, his head, his neck and his shoulders.

Throughout his stay in hospital, Mr Atlantic was on bed-watch and on an ACCT. The first ACCT was closed at 2.30 pm on 24th August 2010. The ACCT was reopened by 6 pm on the same day.

During his stay in hospital, Mr Atlantic was visited by Healthcare staff. Regular phone calls were also made to the hospital by Healthcare staff to understand how Mr Atlantic was responding to treatment. This information was shared with Healthcare staff. The prison carried out regular security checks and updated Healthcare on any relevant developments.

Mr Atlantic remained in the Royal London Hospital until 14th November 2010 when he was transferred back to the Whittington Hospital. At the time of writing, Mr Atlantic is again residing in the Healthcare unit at HMP Pentonville.

The Head of Healthcare launched a Serious Untoward Incident (SUI) investigation, whose report is dated 8th December 2010⁵⁶; the report was amended on 18th January 2011 further to questions from NHS London. It's unclear when exactly this investigation was launched. The Head of Healthcare took this decision based on the nature of the injuries suffered by Mr Atlantic, the fact that Mr Atlantic was hospitalised as a result of the injuries, and to ensure that the establishment's "procedures are safe enough that [such a incident] couldn't re-occur". The intention was to look immediately at what had taken place.

On the day after the incident, the Governor also asked that the Safer Custody Manager and the Health and Safety Manager attend the Healthcare unit to assess the situation and "make recommendations with regards to what had happened and how we ensure that it doesn't happen again".

The SUI investigation concluded the following⁵⁷:

- "Notable practice. The work of nursing staff on 23.8.10".

⁵⁵ C5 and T11 are individual vertebrae within the spine. C5 is in the cervical spine; T11 is in the thoracic spine.

⁵⁶ See Annex 11: Serious Incident Investigation report and action plan

⁵⁷ See Annex 11: Serious Incident Investigation report and action plan

It's unclear to the author of the Article 2 Investigation on what basis this conclusion was drawn and what it actually means.

- “The quality of his admission information on this EMIS record was not of a quality that should be expected and very little additional detail was gathered.”

By this, the Head of Healthcare meant that more could have been done to include clinical views and information that would have helped to develop a picture of someone's care rather than just recording assessments, adopting a procedural stance, and gathering basic information only. The Head of Healthcare has stated that he was encouraging nurses to do this, and was an area of training which he had addressed. One of the aims was to ensure that records should provide a trail which tells the story of what staff have been doing. It is unclear to us how this encouragement is being given, nor the extent to which clinical staff have actually changed their behaviour towards what is desired.

- there was no evidence that a discussion had taken place between Healthcare and discipline staff about moving Mr Atlantic, whether it was safe to do so, and whether the proposed escort arrangements were adequate. It was identified that in future these discussions should take place and be recorded.

We understand that these discussions should be taking place as part of the morning and 13.30 handovers. It's unclear to us what has been put in place to ensure that these discussions do indeed take place and are recorded.

- out-of-date admissions protocol, with staff working “on a basis of custom and practice”. The Head of Healthcare's desire was to have something that made staff reflect more on the importance of bringing people on and off the unit under some kind of systematic review and to use the EMIS (now SystemOne) admissions template.

A clear admissions protocol forms part of the prison's recently introduced 'Operational Policy for the Inpatient Unit'.⁵⁸

- “no risk assessment of the stairwell area” or rest of the video-link route. The Healthcare unit had been open for five years prior to the incident and no prior incidents had taken place in that area. A number of prisoners had been moved through that area during the course of those five years.

As the video-link route is at single-storey height, and the fact that at the time, there was no history of similar incidents taking place, the expectation is that no risk assessment should have been undertaken.

⁵⁸ See Annex 16: HM Prison Service. HM Pentonville Healthcare. Operational Policy for the Inpatient Unit. 04/01/11

One of the principal actions taken as a result of the incident and ensuing investigation was the direction that no prisoner should be escorted up and down the stairs where the incident took place. Staff were instead instructed to use the stairs going directly onto each of the two Units which themselves were blocked, or alternatively, the lift. Although consideration was given to it, it was deemed impractical to cage or block in the stairs where the incident took place.

The stated lessons learned as a result of the SUI investigation were:

- All patients moved through an alternative stairwell or lift where the risk is assessed to be lower
- “Stronger communication and operational policy will support healthcare staff by providing clearer guidance.”

The following recommendations were made as part of the SUI report:

- “All movements on and off the healthcare unit should be reviewed and the outcome recorded into the patients records [by] a member of staff to ensure any potential risk is safely managed. Patients must not be moved until this assessment is completed.”

This has been implemented via the new operations policy in which there is guidance around admissions and movements. An operational memorandum and staff information notice was circulated in September 2010.

- “A healthcare protocol regarding patient movements should be agreed and shared with the prison management.”

This protocol now forms part of the prison’s ‘Operational Policy for the Inpatient Unit’.⁵⁹

- “that a health and safety inspection be carried out of the areas leading from the inpatient unit and any adaptations completed as necessary.”

An immediate risk assessment of the area was conducted by a prison Health and Safety Officer on 25th August 2010. The officer recommended that any patient on an ACCT and/or with mental health problems should not be escorted on that stairwell. We understand that this recommendation has been enacted.

- “Further audit of record keeping to be carried [out], including healthcare admissions”.

⁵⁹ See Annex 16

Regular audits of the quality of record-keeping were started in November 2010. These monthly audits are reported through the prison's Healthcare Clinical Governance Committee. Attempts are being made to try and develop people's record-keeping skills. It was further recognised that record-keeping is often a criticism made in SUI investigation reports. The Head of Healthcare is reasonably satisfied that the standard of record-keeping is better but that "there's still a way to go".

In terms of implementing the new operational policy, the mechanisms include dissemination through team meetings, intranet, and availability of hard copy documents.

The SUI investigation report was shared with the Head of Prisoner Care, the prison Governor and the Healthcare Senior Management Team with a view to cascading the learning points through team meetings and individual supervision sessions.

The constant supervision HCA who witnessed the incident on 24th August 2010 met Mr Atlantic again in hospital on one of her placements. She was shocked to see him, having assumed he had died as a result of his actions on that day.

PART 3 – THE ISSUES THE INVESTIGATION EXAMINED, CONSIDERATION AND FINDINGS

CHAPTER 8. HOW EFFECTIVE WAS THE RESPONSE TO THE INCIDENT?

The Orderly Officer on duty is responsible for incident response. If there's an alarm, the Orderly Officer should attend the incident and liaise with Healthcare. If an emergency escort needs to be arranged to go out to hospital or if an ambulance is needed, the Orderly Officer is responsible for making the arrangements to effect the escort and for completing the necessary paperwork. He/she is also responsible for ensuring that other security and cuffing procedures are followed.

The Orderly Officer is also responsible for checking the welfare of staff following an incident and to ascertain whether they need the support of Care Teams.

On the evidence we have seen and heard, we conclude that the response to the immediate incident was very effective from both a security and healthcare perspective. The incident was well-managed and Mr Atlantic received the care he needed at that time. The risk of possible spinal injury was identified immediately and dealt with in a manner that minimised the possibility of further injury.

However, following the day of the incident, no attempts were made to check on the welfare of the Healthcare Assistant who accompanied Mr Atlantic and the officer during the escort to the video-link. The HCA in question had assumed that Mr Atlantic had died as a result of his actions. She discovered by chance that he was alive, when working in the hospital in which Mr Atlantic was recuperating. Not surprisingly, discovering he was alive under these circumstances was experienced by the HCA as both shocking and upsetting.

We found no evidence that, in the days following the incident, further support had been offered, or information disseminated to staff about what had happened to Mr Atlantic beyond what was picked up on the 'grapevine'. The hard-hitting nature of the incident is reflected in some of the following comments made:

"It was actually quite horrific, by incidents that I've seen. It's certainly one of the ones that's stuck in my mind. Every time I go to that staircase I see him laying there in my head"

"I don't think I'll ever forget that incident. It was a particularly disturbing incident."

"[the video-link Healthcare Assistant] was in a dreadful state. I think she was incredibly shaky...she was in absolute bits"

"in the rest room...everybody was sat in there, very, very shaken"

"[the video-link HVA] was very affected. Very, very affected."

Given the unusual nature of the incident, it's not surprising that people were curious and wanted to know what had happened. When the Healthcare Assistant returned to the Healthcare unit a few weeks following the incident, no acknowledgement was made as to what had happened to her.

We recommend that following serious incidents, measures are taken at HMP Pentonville to ensure that support is provided, and information is actively disseminated, beyond the day of the incident itself. Responsibility for how this support is provided and how information is disseminated should be agreed at the post-incident hot debrief so that respective responsibilities are clear, rather than hoping that individuals will take the initiative. This action should help to reinforce the message that the organisation cares about the welfare of its staff.

CHAPTER 9. WAS THE MEDICAL AND PSYCHIATRIC CARE OF MR ATLANTIC ADEQUATE?

Much of the following draws directly from the clinical review conducted by Dr Ian Cumming.

FORMULATION OF RISK

There is little doubt that everyone we spoke to shared the view that Mr Atlantic presented a risk of suicide; this conclusion was based on the earlier incident of self-harm immediately following the alleged offences that took place shortly before his arrest on 13th August 2010. In addition to this, there are occasions when Mr Atlantic had referred to suicide implicitly or otherwise following the alleged offences. These include:

- In the police station, Mr Atlantic said, “I want out of here”.⁶⁰
- In the police station, the Community Nurse Practitioner noted, “states aimed to end his life when [he had] inflicted wounds” to himself⁶¹
- The following entry in the Police Custody Records, “He will kill himself if left alone.”⁶²

Perhaps equally important is the fact that we could find no evidence that anyone thought that Mr Atlantic did *not* represent a risk, and those who were asked, thought him to represent a high risk.

It is more difficult to address whether it’s possible to estimate the severity of the risk to Mr Atlantic, and whether the measures in place were adequate enough to address it. Risk is not a static phenomenon and it would be facile to consider that determining risk upon one measure or assessment could adequately capture risk. It’s an area that can change and sometimes rapidly. For example, an individual who tells a carer that they have no intention to self-harm might be expressing the risk in other forms; a person’s desire to end their own life might be something suddenly contemplated or acted upon rather than rehearsed.

Mr Atlantic’s lack of communication, suggesting that he was not interested in life, could be considered as an added risk factor. However, this is speculative as it doesn’t take into account the nature of his pre-morbid personality which, in the short timeframe we are considering here, was simply unknown; in other words, his psychological functioning prior to the attempt on his own life was not known. Thus, Mr Atlantic might have been a person who was not easily able to share or discuss feelings or emotions. Only with time would this become apparent. Overall, it is our view that in light of the short timeframe (12 days between his arrest and the serious self-harm incident on 24th August 2010) and his poor engagement, it was not possible

⁶⁰ Annex 2: Police Custody Records, 19/08/2010 – 21/08/2010; Risk Assessment, Version 1, 19/08/2010

⁶¹ Annex 2: Police Custody Records, 19/08/2010 – 21/08/2010; Detained Person’s Medical Form, 19/08/2010

⁶² Annex 2: Police Custody Records, 19/08/2010 – 21/08/2010; Risk Assessment, Version 1, 19/08/2010

to determine the severity of the risk beyond the forming the view that Mr Atlantic represented a raised risk.

In light of this conclusion and in the absence of active self-harm whilst in custody, we view the measures utilised in the prison as typical, appropriate and at the limit of what could be provided. Mr Atlantic was in a gated cell, under continual observations, and on an ACCT. This ACCT was opened almost immediately upon his arrival at HMP Pentonville. Active self-harm in prison might have led to extra measures being taken, but this is by no means certain. In the short timescale of Mr Atlantic's custody at HMP Pentonville, i.e. a little less than three days, before the event itself, the prison was very much at a stage of assessment of, and developing knowledge about, Mr Atlantic.

FORMULATION OF MENTAL HEALTH

Looking at the medical and psychiatric records, few of the entries within EMIS or the ACCT contained any formulations or comments beyond observations around what the prisoner was doing. A key limiting factor in this was of course the lack of engagement by Mr Atlantic himself. Thus, even if either there had been a determination to go beyond the objective comments, there is little evidence at that stage that Mr Atlantic would have engaged.

In spite of the short timeframe and lack of engagement on the part of Mr Atlantic, we feel that the quality of ACCT and EMIS entries could have been better. This is based on the fact that interviews with staff during the course of this investigation have built up in our minds a more detailed and coherent picture of Mr Atlantic than was evident from ACCT and EMIS entries alone. For example, it was clear through the course of our interviews that Mr Atlantic was interacting better with male members of staff than with female members of staff. Although it would have been too early to have had an impact on who interacted with him in the period leading up to the serious self-harm incident, had this fact been recorded and further observations made, this might have influenced later decisions regarding assigning staff to specific duties.

There were a very limited number of comments around Mr Atlantic's mental health and there was no formulation of it.

Regarding the period before Mr Atlantic's arrival in prison, in terms of the information received from the hospital, the prison had received from Barts and The London NHS Trust a Discharge Summary⁶³ focused upon Mr Atlantic's physical health. The Discharge Summary listed his injuries and the surgical repair that had taken place, and included details of future outpatient appointments, namely for a plastic surgery review and for occupational therapy follow-up. We note that the 'Additional Information' section of the Discharge Summary includes comments from the Psychiatric Liaison Nurse and the likely Liaison Psychiatrist which indicate that whilst Mr Atlantic was in the Trust's care he had been seen by mental health services in the hospital. However, there is no record of their input.

⁶³ See Annex 6: Medical reports and records

This input would have been useful and it is likely that it would have benefited the prison. Without it, assessments of mental health had to essentially begin 'from scratch'.

We note that the tendency to record observations was not followed by interpretations. In reality, there were more comments referring to mental health in the ACCT review and in some ACCT entries than in the medical record from EMIS. Opportunities to develop a formulation of mental health, albeit tentatively, from more indirect issues, for example, declining a TV or radio were missed.

We note that the forensic psychiatrist with Barnet, Haringey and Enfield NHS Trust had attempted to see Mr Atlantic twice on 23rd August 2010. In the first visit, he had approached in the morning and noted that Mr Atlantic was asleep, so he decided to return in the afternoon. In both the psychiatrist's notes and interview, he recalled very limited response when he returned in the afternoon and, largely after a rebuttal from Mr Atlantic about coming back the following afternoon, he left. This would seem reasonable in that responding to a prisoner's wishes is a mechanism to establish rapport. The psychiatrist was thus unable to conduct a psychiatric examination beyond observations from that brief contact and the information collated to that point.

We agree with the psychiatrist's decision to stop Mr Atlantic's anti-depressant medication. We do not feel that the cessation of medication would have had any relevance to the incident of serious self-harm the following day.

On balance, we feel that Mr Atlantic's medical and psychiatric care cannot be criticised. The short timescale (i.e. a little less than three days) and lack of his engagement meant that the medical and psychiatric staff's normal procedures were considerably hampered and still mustering. If the timescale had been much longer before the incident, then criticism would have been more pertinent. We do, however, note that the assessment in HMP Pentonville could have been enhanced by more information from Barts and the London NHS Trust.

CHAPTER 10. WAS THE NATURE OF THE VIDEO-LINK ESCORT ADEQUATE?

An escort of one officer is normal for transfers to a video-link court appearance. The question of whether it was adequate in this particular case is clearly pertinent to the investigation. In answering it, we suggest looking at what typically determines the nature of an escort. This is driven by known facts. That is to say, if there has been a history of previous assaults on staff, this would influence whether the escort be increased to two officers or more. The focus is upon the danger to officers rather than the potential danger to the prisoner who is being escorted. We believe this to be a reasonable line of thought. As there were no previous incidents involving risk to officers, it follows from this that an escort of one officer be seen as reasonable.

In his interview transcript/statement, Mr Atlantic raised the issue of *how* he was escorted. His recollection is that when in police custody, he was escorted by being held by an officer. This led to an expectation on his part that he should have been escorted in a similar manner inside Pentonville. Whilst we acknowledge the point he made, we see no grounds for him to have been escorted in this way. Even if there had been grounds, maintaining a hold on a prisoner whilst opening and closing prison doors is simply not practical.

We understand that a new policy has now been implemented in the Healthcare unit. This states that “the movement of all identified high risk patients on and off the Inpatient ward must be a minimum of two officers”.⁶⁴

⁶⁴ Annex 16: HM Prison Service. HM Pentonville Healthcare. Operational Policy for the Inpatient Unit. 04/01/11

CHAPTER 11. WERE PREPARATIONS FOR THE VIDEO-LINK COURT APPEARANCE ADEQUATE?

Although the court appearance was clearly stated as a trigger in the ACCT documentation⁶⁵, we were unable to find any evidence that it was given consideration at any point by Healthcare staff beyond its practical arrangement. In other words, we found no evidence that a discussion took place between discipline staff and clinical staff about moving Mr Atlantic to the video-link on the morning of 24th August 2010. The only consideration given, for which we have evidence, was ensuring that a nurse accompanied Mr Atlantic to the video-link. We have no evidence that an assessment was made of Mr Atlantic's fitness for court, either from a physical well-being perspective or from a mental well-being perspective.

Whilst we acknowledge that a video-link court appearance is typically more low-key than a personal court appearance, we don't believe that this in itself removes the need to give the issue due consideration. Such consideration should extend to a focus on both the escort *to*, and the arguably more critical time *following*, a court appearance. As the Charge Nurse acknowledged, "there should have been a lot of discussion in terms of how to manage this person when they are taking him to the video-link".

Whilst several members of staff have argued that putting a person on a constant supervision regime is the most that can be done in terms of risk management, we believe this view fails to consider the nature of the constant supervision, the attempted interaction with the prisoner, and how primed and sensitised staff are to likely changes in prisoner mood and behaviour.

What is described above contrasts with what we understand was taking place on Mr Atlantic's return to HMP Pentonville following the incident. For example, we understand that regular case conferences have been taking place to consider what is going on from his physical care and mental healthcare perspective.

Although there is no evidence that consideration was given to the trigger in question, we can speculate that some consideration may have been given to it in deciding it was safer for him to have the video conference than to appear in court in person. Even if consideration had been given, this should have been communicated to those involved in Mr Atlantic's care and management.

After hearing about the incident, the forensic psychiatrist stated that he was surprised that staff had not chosen an alternative route to video-link that avoided the use of an open stairwell, and that he personally would not have taken Mr Atlantic to video link by the staircase in question.

The psychiatrist stated that when he recommended a continued one-to-one, it was on the basis that the patient stayed in his cell. However, we have no evidence that he communicated this fact to colleagues. If there was a proposal to take Mr Atlantic out of his cell, the psychiatrist would have upgraded the one-to-one supervision to

⁶⁵ See Annex 7: ACCT Plan 21/8/10 - 24/9/10

“something more serious”. The psychiatrist affirmed that he would have expected the team to have come together and discussed the video-link appearance before making a decision as to how Mr Atlantic would be moved. Had the decision been his, the psychiatrist would have adjourned the video-link appearance. However, we have found no grounds for him drawing this conclusion as a psychiatric assessment had yet to take place. We are also unclear what the ‘upgrade’ referred to would entail, given that one-to-one supervision provides the highest level of supervision available.

We feel that more could have been done to brief the escorting officer as to the circumstances of Mr Atlantic’s incarceration, the fact that he was on an ACCT, and the fact that this was the first time he had left his cell since arriving at the prison. This might have then at least primed him for the possibility of something untoward happening.

We think it reasonable that no consideration was given to the video-link route itself, and specifically, the use of the stairs where the incident of serious self-harm took place. There was no precedent for an incident of this type in either the Healthcare unit at HMP Pentonville or, as far as we are aware, in any other Healthcare unit built on the same design. We understand that hundreds of prisoners had been escorted via this route without prior incident. We don’t believe that Mr Atlantic’s actions could have been foreseen.

On balance, our view is that the court appearance represented less of a trigger; it was more the case that it presented the first opportunity for Mr Atlantic to make a serious suicide bid. As far as the incident of serious self-harm is concerned, it would be speculation to say how planned this had been. For example, it is not clear whether Mr Atlantic had any prior knowledge of the video-link route and opportunities within it for self-harm. Despite the nature of the court appearance as a trigger, we maintain that Healthcare staff should have come together in advance of the escort to discuss the issue.

We can only speculate whether Mr Atlantic’s decision to thank one of the officers, and say goodbye to him, indicated that he was planning to end his life.

We recommend that, as a matter of course, escort officers at HMP Pentonville are provided with a briefing as to the nature of the circumstances of the prisoner in their charge and what has been learned about that prisoner. This should provide further clarity for the escort officer as to what he/she is being tasked to do, and help to reduce levels of ambiguity.

A recommendation relevant to ACCT triggers is provided in Chapter 15.

CHAPTER 12. ARE STAFF COMPETENT IN THE USE OF ACCT PROCEDURES?

ACCT TRAINING IN GENERAL

The importance of ACCT training was voiced by a number of those we interviewed. As the Head of Healthcare stressed, “ACCT training is a must and you shouldn’t be working in a prison without having had it.”

However, despite interviewing 18 members of Healthcare staff who came into contact with Mr Atlantic, we found that only ten of these members of staff had received, or remembered receiving, formal ACCT training. This included both permanent and non-permanent prison staff. This is despite the fact that the respective PSO (PSO 2700 – Suicide Prevention and Self-Harm Management) in place at that time⁶⁶ mandated that “all staff in contact with prisoners must be trained at least to ACCT Foundation Level”.⁶⁷ This mandate extended to non-permanent staff such as those from agencies and locums. A disproportionate number of clinical staff had failed to receive ACCT training relative to the number of discipline staff who had received the training.

We are further concerned that the findings above are at odds with assumptions being made by some senior managers, for example by the senior manager who was the Duty Governor when the incident took place on 24th August 2010, who told us that HMP Pentonville is “very focused” upon ACCT training and that there has been a drive to make “more meaningful [ACCT] entries”. This senior manager went as far as to say, “There’s no way anybody in this prison couldn’t be aware of the emphasis put on ACCT documents.” As indicated by the relatively small percentage of Healthcare staff trained, our findings did not bear out this position. As the SO Safer Custody put it, “My initial concern would have been the training of everybody in terms of ACCT Foundation Training...there doesn’t seem to be a structured approach as to who’s had it and who hasn’t.”

Some staff recall receiving only informal ACCT briefings from colleagues that covered aspects of ACCT such as how to make meaningful entries in the ACCT document. Other members of staff ‘picked up’ an understanding of ACCT from reading relevant documents and observing how others used ACCT.

We recommend that a single system be introduced at HMP Pentonville that records who has received ACCT training and when the training took place. This system should cover both staff in the main prison and those working on the Healthcare unit. It should also cover both temporary and permanent staff. We suggest that the same system be used to monitor when refresher ACCT training is due.

We recommend that a system-owner be assigned to ensure that action is taken, and that ongoing monitoring takes place. We suggest this owner should be the Safer Custody Senior Officer (SO). We also suggest that a member of staff in Healthcare is made responsible for liaising with the Safer Custody SO to provide this person with the information they need. We suggest that both individuals are involved in the

⁶⁶ PSO 2700 has since been replaced by PSI [Prison Service Instruction] 64/2011 – Safer Custody.

⁶⁷ See Prison Service Order 2700: Suicide Prevention and Self-Harm Management, Section 1.2.1

design of the system to help promote clear ownership and to ensure the system is not perceived by users to be burdensome.

ACCT TRAINING OF NON-PERMANENT STAFF

We understand that the SO Safer Custody now has a database of all the ACCT training that she has delivered, and a list of all operational staff. We understand that during the course of the last 18 months or so the SO has received an updated list of all Healthcare staff, with an agreement that all staff will be trained to ACCT Foundation Level. We understand that majority of staff have now received this training.

The SO Safer Custody acknowledges, however, that problems continue regarding administering this because there is no central point in the prison responsible for the employment and management of all staff. This function is split between NOMS and Healthcare. Bank nurses and locum staff are often brought in on a 'needs' basis only. This action may be taken at short notice, and bookings may be of a short duration. The Safer Custody team is poorly informed by Healthcare about which staff are joining and leaving Healthcare and therefore who should be in receipt of ACCT training.

We understand that the Practice Manager in Healthcare has been tasked with getting his deputy to compile a monthly spreadsheet to record new staff members, including locum staff, and whether they have had the basic forms of training to work in prison. However, there is no evidence that this activity is being co-ordinated with the Safer Custody team's efforts.

We have identified that Healthcare's Service Manager, Mental Health and Substance Misuse, is now monitoring who has been formally ACCT-trained in her area, and who has not, although we have been unable to ascertain whether this monitoring is taking place for everyone in Healthcare. We've been informed by Healthcare that ACCT training is now part of new nurse induction procedures so that, "no-one's left in any doubt in this prison about their responsibilities [with respect to ACCT]". What remains unclear is how this activity is being logged and monitored, and to what extent the SO Safer Custody is being informed as to what is and is not happening with respect to the training and induction of clinical staff.

No process is in place to ensure that temporary staff are ACCT-trained. This includes those coming from the bank or nursing agency, who may only be undertaking shifts for a particular purpose and who may be booked at short notice.

The importance of bank and agency nurses understanding ACCT is not in dispute. As the current SO Safer Custody put it, "a lot of [agency nurses] work in Healthcare and you've got probably six to nine ACCTs on average, out of 22 prisoners on an ACCT, in Healthcare. So absolutely, it's a priority that they get the [ACCT] training as well."

Assuming that it's impractical for non-permanent clinical staff to attend an ACCT training course as permanent staff members do and long-term bank and agency nurses could, we recommend that a protocol be developed at HMP Pentonville to ensure that these staff are at least provided with a systematic ACCT briefing. This

could be incorporated into a broader prison induction (see Chapter 13). We recommend that this protocol be developed in collaboration with Safer Custody.

HEALTHCARE STAFF RECORDS

We found no evidence that reliable records were being maintained as to who had been employed from either the bank or the nursing agency to work on the Healthcare unit. As there was no clear audit trail, it was difficult to identify who had been employed on a temporary basis to care for Mr Atlantic.

The fact that temporary staff signed or initialled the ACCT On-going Record, rather than printing their name, created a further obstacle to understanding who was doing what on a given shift.

This lack of audit trail has implications for workforce management in Healthcare in that it's unclear at the start of a bank/agency worker shift how much briefing needs to be provided with respect to ACCT or, indeed, what it is to work in a prison as opposed to in an outside hospital, for example. For the same reason, it's also unclear at that point how much briefing individual bank or agency people need about what they should expect to encounter when working in the prison environment, and what will be expected of them in terms of fulfilling their role and duties. These may be expected to differ substantially from those in a community setting.

We understand that the issue of staff records has since been addressed in part through the transition to NHS Professionals that has taken place. As all bookings with NHS Professionals are undertaken electronically, we have been informed that this provides an instant audit trail for future use.

It is less clear how much attention Healthcare pays to the amount of experience of working in prisons a booked healthcare worker has; and therefore how much induction and briefing about ACCT needs to be provided before a scheduled shift.

We recommend that HMP Pentonville's Healthcare unit keep a log of temporary staff who have received a prison induction, whether they be booked through NHS Professionals or otherwise. We think it's important that this log is easily accessible and made visible to help promote ownership for the provision of these prison inductions.

To improve current audit trails, we recommend making it a requirement at HMP Pentonville that all staff print their name on the ACCT On-going Record rather than relying on initials or signatures to identify who has made each respective entry. We suggest that amendments are made to the prison's 'Guide to Management Checks of Open ACCTs' to reflect this change.

DEALING WITH NON-COMMUNICATIVE PRISONERS ON ACCT

Mr Atlantic communicated little during the period of slightly less than three days leading up to the incident. This was never more the case than when attempts were made to engage him with ACCT. This lack of communication and Mr Atlantic's 'no comment' responses were interpreted by some as simply a 'lack of information'. In fact, this lack of communication is best interpreted as a potential indication of risk. Those witnesses whom we interviewed and who reported having been formally trained in the use of ACCT acknowledged that they had not been equipped to interpret a lack of information. The ACCT documentation reviewed is of limited use in scenarios in which there is little or no communication with the prisoner, because these documents rely on verbal information being provided by the prisoner in question. Without this input, the danger is that staff may become complacent about the level of risk present when faced with a non-communicative prisoner.

We recommend that part of the ACCT training (Foundation and Case Manager) should be modified by the Prison Service to convey an understanding of prisoner non-communication and how this should be interpreted, particularly when formulating risk assessments.

ENSURING ONGOING COMPETENCE IN THE USE OF ACCT

Of all those witnesses whom we interviewed in autumn 2011 who had received formal ACCT training, none had received any ACCT refresher training. This is despite the fact that some of these witnesses had received their original training as far back as 2007, and the fact that some witnesses were of the view that refresher training should be provided every two years. We have been unable to ascertain whether this is in fact the prison's local policy.

We understand that at HMP Pentonville refresher training for the ACCT Foundation Level is available but not mandatory. It takes the form of an 'Introduction to Safer Custody'. A new package is being developed and will be delivered April 2012 onwards. Should an issue of individuals making poor entries be identified by the wing SO, for example, a suggestion is made that they attend refresher training. There's an acknowledgement by the Safer Custody team that staff resources are limited, making any widespread provision of refresher training a challenge. However, it's encouraging that all staff are invited to attend a refresher.

A small percentage of clinical staff with whom we talked confirmed that they had received formal ACCT training. We are encouraged that the matter has been discussed with the Head of Healthcare and that a plan is in place to train all Healthcare unit staff to ACCT Foundation Level as soon as is practicably possible.

CHAPTER 13: ARE BANK AND AGENCY STAFF ADEQUATELY PREPARED TO CONDUCT ONE-TO-ONE SUPERVISION DUTIES?

Although agency and bank staff are medically-trained, there are other areas where we call into question their preparedness to conduct one-to-one supervision duties in a prison setting.

Bank and agency nurses do not receive formal ACCT training from prison staff. No systematic procedure is in place to ensure that these healthcare workers have sufficient understanding of ACCT before engaging with it. This issue is explored more fully in Chapter 12.

Despite the fact that bank and agency nurses do not receive formal ACCT training, no safeguards are in place for those who have never worked in a prison before. Such safeguards would relate to the individual's own safety and security, as well as that of the prisoner. In our view, factors that would contribute to the individual's safety and security would be their ability to raise an alarm in line with prison protocols, their ability to use a radio if they are provided with one, their knowledge of other staff working on a wing, familiarity with the layout and routes in the areas of the prison in which they would work, and their familiarity with disarming procedures.

In addition to issues of continuity of care and competence, clinical staff who do not have prison experience are more likely to distance themselves rather than engage with the prisoners they are dealing with and caring for. This caution is perfectly understandable when faced with unfamiliar situations and surroundings. This is far from ideal, however, in supporting a prisoner's psychological well-being. Witnesses also indicated that any handover is typically brief. The bank or agency healthcare worker may also not be familiar with the medical records system, and would be relied upon to raise this as an issue with permanent members of staff.

As one Healthcare manager stated, "[bank and agency staff] ... perhaps don't have that prison base of knowledge which is so essential. ... Healthcare in a prison is very, very different [to] providing care in an NHS setting."

It's particularly concerning that some of the above concerns are referred to in the Prisons and Probation Ombudsman (PPO)'s Article 2 investigation report into the attempted suicide of another prisoner at HMP Pentonville in 2001.⁶⁸ The following specific recommendation was made as part of the report published in May 2008, "I recommend that all agency nurses at Pentonville are given a full induction into prison procedures and practices, particularly with regard to suicide prevention."⁶⁹

At present, temporary clinical staff do not currently pass through any formal prison induction even though some may have never worked in a prison before.

⁶⁸ Report of an article 2-compliant investigation into the circumstances surrounding the attempted suicide of D at HMP Pentonville on 27 December 2001. Stephen Shaw CBE, Prison and Probation Ombudsman for England and Wales. May 2008

⁶⁹ Ibid, p. 126 at 7.103 and p. 176, recommendation 3.

We've been informed that some of these concerns are being addressed by the Safer Custody SO and the introduction of a 'Healthcare induction sheet'. This sheet is signed by new staff on their first shift, as well as by the nurse providing the induction and handover.

We recommend that at HMP Pentonville all temporary staff receive a prison induction before working in the prison for the first time. As well as covering safety and security issues, this induction should provide coverage of the ACCT Foundation training module (which has since been superseded by 'Introduction to Safer Custody') and the use of a wing's Observation Book. Alternatively, the onus should be placed on the agency/bank to provide only staff who have experience of working in prisons and who have received ACCT Foundation training in the recent past.

CHAPTER 14. IN WHAT REGARD IS ACCT HELD BY THOSE WORKING WITH IT?

Our findings suggest that ACCT is generally viewed in a very favourable light by staff working with it. This includes both healthcare and discipline staff, with one observing that “it’s not an important document, it’s a *vital* document”.

Some of the witnesses we interviewed acknowledge that there are pockets of staff who see ACCT as a means by which prisoners can manipulate ‘the system’ and receive more attention than they otherwise would if they were not on an ACCT. Whilst it’s important to understand these views, it is also important to guard against any growing perception that the process is not a useful one.

ACCT is seen as effective if used as it was designed to be used, that is in helping to support people who are vulnerable or at high risk of suicide or self-harm. Case Reviews are viewed as helping with future risk management and, if used effectively, help to get a person taken off an ACCT.

The ACCT is also seen as helpful in giving prisoners targets to work towards, and giving them a sense that their needs are being catered for in a systematic way.

In Healthcare, the impression given is that there is more time to engage with the prisoner and get to know the prisoner and his issues, as the staff to prisoner ratio is better than in the main prison. It’s recognised that the ACCT process “creates a strong relationship ... between the staff and the prisoner, and it certainly creates trust.” What is achieved through these interactions should be reflected in the ACCT entries made. Although there was a limited opportunity to develop a strong relationship with Mr Atlantic, witnesses acknowledge that the quality of ACCT entries is variable at best, even when this opportunity presents itself.

The forensic psychiatrist whom we interviewed observed that prison officer knowledge of ACCT is “decisively better” than it is among nursing staff. The SO Safer Custody commented, “I think the ACCT document is sometimes considered as an operational document rather than a Healthcare medical document. ... In my experience, the entries of Health Care staff ... are not always as thorough as they should be.”

Whilst ACCT entries are seen as creating a useful picture of ‘what’s going on with a prisoner’, some nurses think that ACCT entries are the responsibility of discipline staff rather than being everyone’s responsibility. We feel that this view fails to attach sufficient importance to the ACCT process and to the contribution that good quality entries make in looking after at-risk prisoners.

We recommend that the views of clinical staff with respect to ACCT are sought when they attend ACCT training at HMP Pentonville. By understanding in what regard ACCT is held, ACCT trainers will be better placed to explore with those attending how shared ownership of ACCT might be best promoted. We recommend that serious consideration should then be given to acting on the outcomes of these discussions as a means of creating further buy-in for ACCT, and of promoting shared ownership among discipline and clinical staff.

CHAPTER 15. HOW WELL ARE ACCT PROCEDURES ADHERED TO?

RECORDING AND ACTING UPON 'TRIGGERS'

Among those interviewed, we found that there were inconsistent views of what ACCT triggers are and how they should be responded to. In the case of Mr Atlantic, and indeed more generally, we found little evidence that triggers were systematically reviewed at Healthcare morning briefing or at Case Reviews.

One of the triggers recorded when the ACCT document was first opened was Mr Atlantic's forthcoming court appearance on the 24th August 2010. We have been unable to find evidence that any consideration was given to this trigger point, even though it is acknowledged and documented that court appearances can be stressful events and should therefore rightly be judged to be trigger points. It's therefore unlikely that a staff member would pay particular attention to the fact that a court appearance has been recorded as a trigger point.

Whilst it was acknowledged after the incident of serious self-harm on 24th August 2010 that the trigger point was appropriate, there is no evidence that it was given any consideration prior to Mr Atlantic being escorted to the video-link. There was no attempt to engage with Mr Atlantic to understand how he felt about the court appearance, and what the best and worst case scenarios might be for him, in his view.

We recommend that HMP Pentonville's Healthcare unit takes steps to understand why ACCT triggers are not always given due consideration in prompting Case Conferences and documented discussions among staff. With this understanding, steps should be taken to improve the current situation. We recommend that any steps identified go beyond simply reminding or telling staff that triggers should be given consideration and that other mechanisms for changing behaviour are formulated and implemented.

ACCT ENTRIES

Many staff interviewed recognise the importance of quality ACCT entries. As one interviewee highlighted, "Good quality entries twice a day are much better than hourly entries saying, 'Man is on bed'". A need to interact with a prisoner is seen as key to this, as is the need to build a picture of how a person is, rather than recording what the prisoner is doing. It's acknowledged that the quality of ACCT entries in general does vary significantly amongst staff, including bank and agency workers.

As the current SO Safer Custody expressed it, "I think the quality of entries in the ACCT documents are not as good as they should be, and sometimes very poor". Poor entries are classed as observations, for example, "They're lying on their left-hand side" or "Appears asleep" and where no attempt at verbal interaction has been made or recorded. Higher quality entries would reflect whether a prisoner is out on Association, the extent to which they are interacting with other prisoners, whether they appear to be enjoying themselves et cetera.

The lack of quality entries would seem to provide support for the comment earlier in this report sourced from the most recent (2011) HMCIP report on HMP Pentonville that ACCT entries had “few quality entries”.

Exacerbating the problem is the issue of hourly entries being seen as too predictable. This may lead to a prisoner taking advantage of this predictability. It also does little to encourage the recording of meaningful entries. Whilst the expectation is that hourly, but not predictable, ACCT entries be made, a review of Mr Atlantic’s ACCT record indicates that entries were generally made on the hour, every hour.

HMP Pentonville also makes use of ‘Special Observation’ forms.⁷⁰ These forms describe the following levels:

- “Primary observations: Nurse will make contact with the patient 4 times in an hour.”
- “Close observations: Nurse will accompany the patient around the ward and remain with [sic] eyesight at all times.”
- “Total Observations: Qualified nurse will accompany the patient always within length of arms [sic].”

We have been unable to ascertain whether these forms are local to HMP Pentonville, nor in what circumstances they are used.

Whoever is completing these forms is then expected to provide 15-minute entries under ‘comments’. Reviewing the entries made for Mr Atlantic, it’s hard to see what value this information has in his, or indeed any other prisoner’s, care and management. All entries are non-interpretive observations, for example, “Sleeping” and “Lying on his back”. It is also unclear to the author how this information integrates with the ACCT document or SystemOne entries.

There was also clear variability in the quality of ACCT entries made. What we found striking was the comparison between the picture that was created of Mr Atlantic through the interviews we conducted and the picture of him that emerged from the ACCT entries alone. The two pictures were quite different. Notwithstanding the short time that Mr Atlantic was in Healthcare, the ACCT entries did little to create a picture of Mr Atlantic. For example, little reference was made to his mood or the extent to which he was eating and drinking.

The poor quality ACCT entries extend to Care Plans. One Senior Officer commented that there “needs to be achievable goals rather than just something that [prisoners] have got an issue with that we can’t actually fix.”

We understand that there are existing mechanisms in place to ensure that quality entries are made. These mechanisms include daily ACCT document checks by the respective wing SOs, weekly checks by Wing Governors and periodic checks of closed ACCTs by the Safer Custody SO. Checks may be followed up with a request from the

⁷⁰ See Annex 9: Complete Special Observation forms, 21/8/10 – 24/8/10

Safer Custody team to respective line managers for individuals to attend the 'Introduction to Safer Custody' training session.

The 'Guide to Management Checks of Open ACCTs'⁷¹ was designed in 2011 by the SO Safer Custody at HMP Pentonville to help individuals conducting checks, and sets out what is expected from that person. Any observations, either good or bad, should then be fed back to the person whose entries they are.

We recommend that existing mechanisms for ensuring that quality ACCT entries are made at HMP Pentonville be enhanced. This process may involve:

- **making the process easier for staff by OSRR providing guidance notes to accompany the ACCT document. These guidance notes should make explicit what is being looked for and not looked for, providing examples to help convey the key messages**
- **praising individuals who are providing quality entries**
- **utilising the power of peer pressure by making it public when good entries are being made**
- **identifying deterrents against making poor quality entries**
- **increasing staff's sense of involvement by providing a forum for individuals to talk about what using ACCT is like**
- **connecting staff with the outcomes of their work, i.e. finding a way of demonstrating how quality ACCT entries have actually made a difference. This should help reinforce the idea that making quality entries really does matter rather than making entries because the 'process' demands it.**

We recommend that HMP Pentonville moves away from the regime of hourly ACCT entries to help encourage the recording of more meaningful entries.

We recommend that HMP Pentonville's Healthcare unit reviews its use of 'Special Observation forms' and clarifies what value, if any, they are adding to the care and management of a prisoner who is on an observation regime.

CASE REVIEWS

The way in which ACCT Case Reviews regarding Mr Atlantic were documented was inadequate on a number of fronts:

- Location was recorded as "Location" rather than where the Case Review actually took place.
- It was unclear which people, of those who had been invited, actually attended.
- Level of risk was lowered from 'high' to 'raised' by the Deputy Ward Manager on the mistaken assumption that these terms meant the same thing.

⁷¹ See Annex 15: HM Pentonville. Guide to Management Checks of open ACCTs. 2011

There was also a lack of consistency regarding how to interpret Mr Atlantic's lack of communication. Some members of staff saw it as a further indication of risk; others did not interpret a lack of communication in this way, viewing it simply as a lack of information.

We recommend that more is done at HMP Pentonville to make it easier for staff conducting ACCT Case Reviews by clarifying for them what they are trying to achieve and how to fill in the form. We suggest this could be achieved by providing accompanying guidelines. Although it's in a different context, a good example of this approach can be found in the form of the Guidance Notes that accompany the PER form (Person Escort Record form). These guidelines should provide greater clarity and promote greater consistency of approach.

We also recommend that staff involvement is enhanced by seeking out their view about how well or otherwise the Case Reviews are working. There is an opportunity to disseminate this feedback to other prison staff, and make ongoing changes to this element of the process. Encouraging involvement should also promote greater transparency and encourage individuals to challenge existing ways of doing things.

CHAPTER 16. WAS THE CONSTANT SUPERVISION OF MR ATLANTIC ADEQUATE?

In terms of an approach, we found among staff a good understanding of the importance of making an effort to communicate and build up a rapport with a prisoner who is on an ACCT. This communication would extend to each member of staff who dealt with a prisoner on constant supervision introducing themselves to the prisoner and explaining that part of their job is to help him.

We found evidence of these efforts to communicate being made by those staff on constant supervision duties (and by other healthcare and discipline staff), as well as efforts to ensure that Mr Atlantic had everything he needed.

We would expect that people working in prison would be familiar with prisoners who do not want to engage. Usually this attitude on the part of a prisoner is temporary, and rapport can be established to varying degrees. Engagement can be developed by persistence, personal rapport, and familiarity, amongst other factors. However, the short timescale, i.e. a little less than three days, was again important at this point in that there was perhaps insufficient time to establish a meaningful rapport with Mr Atlantic.

Mr Atlantic complained to two individual staff providing constant supervision: to one about shining a torch in his eyes at night and to another about not providing him with more privacy when using the toilet.

We found evidence that temporary healthcare staff undertaking one-to-one supervision were cautious in their approach, seeking approval from a more senior member of the team if necessary before taking a particular course of action. For some of the temporary staff, constant supervision meant just that: constant. In our view, on occasion, this rigid approach failed to provide an effective balance between the care of Mr Atlantic and maintaining his sense of dignity.

The challenges of using temporary clinical staff to carry out constant supervision duties have been highlighted elsewhere. As a one-to-one supervision is focused more upon observations of behaviour than clinical care, we cannot see a strong argument for using clinical staff in preference to discipline staff members, as is the practice at HMP Pentonville. Also, the use of permanent staff in one-to-one observations is likely to result in better and more integrated care than was apparent with Mr Atlantic.

Healthcare managers are now exploring the possibility of using officers for one-to-one supervision.

We recommend that some impetus be created at HMP Pentonville to ensure that the option of using discipline staff for one-to-one supervision is explored (see Chapter 13). Providing clear accountabilities and a timeframe for getting this piece of work done will go some way towards creating this impetus.

CHAPTER 17. HOW EFFECTIVE WAS INFORMATION-SHARING?

ACCT VERSUS EMIS

EMIS is a primary care computer system for patient records. It is a system that is only used in Healthcare, whereas ACCT is used across the whole prison, including Healthcare. Whilst ACCT is not simply a record-keeping system, this chapter focuses on the record-keeping aspect of the ACCT process, and how this is viewed and acted upon relative to EMIS.

We observed a lack of clarity among Healthcare staff about what should be recorded in ACCT and what should be recorded on EMIS (now SystemOne). We acknowledge that this is a common issue and that it pre-dated the implementation of clinical IT systems. We understand that challenges are presented by the following factors: there is often duplication of information, the clinical systems are not near the prisoner, and discipline staff don't have access to clinical systems.

We understand that the record-keeping audit tool⁷² introduced subsequent to the incident of serious self-harm on 24th August 2010 has gone some way towards identifying areas of improvement. The audits have also identified that some nurses have experienced significant challenges in putting information appropriately on SystemOne. This is being addressed through the creation of an 'easy guide' for staff on the use of template and on the inputting of care plans on SystemOne. The process has also highlighted significant concerns regarding some standards for working, which are currently being addressed through formal Human Resources (HR) performance management processes. Examples of these concerns include the quality and consistency of use of templates (including care plans and risk assessments) and a lack of consistency among personnel regarding the quality of entries made, with some entries not enabling readers to gain a sense of the care or treatment delivered.

The Healthcare unit has also introduced, in January 2012, a National Health Service model called 'The Productive Ward'.⁷³ The support and training associated with this includes an emphasis on record-keeping and care-planning.

We recommend the ongoing use of the record-keeping audit tool being used on HMP Pentonville's Healthcare unit, whilst ensuring that it continues to make a tangible difference and informs decision-making, rather than being seen as a paper-filling exercise. Showing staff exactly how it is making a difference should further encourage its uptake, giving them a clear reason for doing what they have been asked to do.

⁷² See Annex 12: Medical Records Audit

⁷³ The Productive Ward. NHS Institute for Innovation and Improvement

We recommend that guidelines be developed and implemented at HMP Pentonville as to what should and shouldn't be recorded in ACCT and SystemOne. These guidelines could be integrated into existing documentation. To make it easier for staff, we recommend that these guidelines include examples of what should and shouldn't be recorded. We suggest that an explicit acknowledgment is made that some overlap of information may be inevitable, but that it is important that discipline and clinical staff alike have as full a picture as possible of prisoners in their care.

Before developing these guidelines, we suggest that work is done to understand both the clinical and discipline staff's perspective with respect to accessing what information they need. We suggest that consideration is made to making changes that don't increase the existing burden of work, but that do ensure that the 'right' information is recorded in the right place.

ACCESS TO ACCT INFORMATION

As the norm in HMP Pentonville Healthcare is for ACCT documents to be always kept with the respective constant supervision nurse, there is scope for information to be missed at morning briefings. We acknowledge that a constant supervision regime is a key clinical concern and is likely therefore to raise a priority rather than reduce it. However, there can be a lack of consultation between the person leading the morning meeting and the nurse carrying out one-to-one supervision. This lack of consultation may explain why the court appearance trigger was not discussed or a Case Review held prior to the video-link escort.

We recommend that at HMP Pentonville recently-made entries in the ACCT document, including triggers, are checked by a member of staff attending morning briefings so that any pertinent issues are identified and discussed in this forum.

SERIOUS UNTOWARD INCIDENT INVESTIGATION

We found little evidence to suggest that the findings of the Serious Untoward Incident [SUI] investigation⁷⁴ were shared with staff. Given the unusual nature of the incident, it's not surprising that a number of staff were expecting to hear what lessons had been learned from the incident. Failing to share findings from the investigation was a missed opportunity to convey to staff that the seriousness of the incident was being acknowledged, and that steps were indeed being taken to understand what lessons could be learned.

We recommend that steps are taken at HMP Pentonville to share findings of future internal investigations, whether they be formal or otherwise, with the relevant audience(s). We would encourage the use of face-to-face fora for this, rather than simply circulating investigation reports. This approach should help enhance the

⁷⁴ See Annex 11: Serious Incident Investigation report and action plan

feeling of staff involvement and would send a clear signal about how transparency is valued and promoted in the prison.

Sharing of information between discipline and clinical staff

At Reception, Mr Atlantic's court appearance on 24th August 2012 was recorded on his ACCT Plan⁷⁵ as a trigger. It was written as "CRT 24/8/10". We discovered that this acronym, "CRT", was not widely known amongst Healthcare staff. The fact that this entry was never queried is further evidence that triggers were not being acknowledged and considered at morning briefings in Healthcare, and in the planning of Mr Atlantic's care by both clinical and discipline staff.

It is encouraging to hear that officers are encouraged to attend ward rounds on the Healthcare unit. This helps ensure that their knowledge and understanding of prisoners feeds into clinical decisions, and generally helps in the two-way process of information-sharing.

This is in line with the recently implemented 'Operational Policy for the Inpatient Unit, HMP Pentonville'⁷⁶:

"An integrated primary nursing and primary officer model of care is consistent with a holistic philosophy of care, and gives both nurses and officers the opportunity to develop a close therapeutic relationship with patients. Care planning should involve a partnership so that the individual's needs can be identified and an individual plan of action constructed by the nurse, officer, lead responsible doctor and patient together."

Having said that, we found little evidence that information was being shared between discipline and clinical staff in the case of Mr Atlantic. Examples in relation to this include clinical staff recording information in EMIS (now SystemOne) but not in the ACCT document. Recommendations for addressing this are made earlier in this chapter.

This gap between discipline and clinical staff regarding information-sharing was also echoed during the course of this investigation. In working with staff and managers from both the main prison and the Healthcare unit, we experienced a level of disconnection between the two. Frustration was also voiced, in particular by the Safer Custody team, who felt that their influence over the Healthcare unit was limited. Healthcare management have pointed out that they have experienced some "operational difficulties" that may have contributed to this perception; however, we have been unable to ascertain the nature of these difficulties.

⁷⁵ See Annex 7: ACCT Plan, 21/8/10 – 24/9/10

⁷⁶ See Annex 16

We recommend that officers' attendance at ward rounds is embedded as a norm on HMP Pentonville's Healthcare unit, if this is not already the case. This should help further improve understanding and promote a sense of collegiate working among discipline and clinical staff.

At an organisational and cultural level, we recommend that further measures are taken to close the perceived gap between the main prison and the Healthcare unit at HMP Pentonville. This should help create a greater sense that HMP Pentonville is functioning as one organisation, comprised of staff and managers working together towards a common goal.

SHARING OF INFORMATION AMONG HEALTHCARE UNITS ACROSS THE PRISON ESTATE

The sharing of information such as experience and examples of good practice between Healthcare units across the Prison Estate appears to be patchy and informal. Whilst regular meetings of Heads of Healthcare used to be commonplace they have now become occasional. With respect to regular contact with other healthcare managers, "we perhaps haven't been as proactive, because we disappear into our own roles in our own prisons", commented HMP Pentonville's Head of Healthcare. Some steps have been taken to encourage Mental Health Trust in-reach managers to meet and share experiences although these meetings are not compulsory.

We recommend that efforts are made to ensure that representatives from Healthcare units across the Prison Estate meet on a regular basis. We feel that the key to making this a reality is ensuring that the agenda for such meetings is clear and agreed as a group. Meetings should then be perceived to be productive and therefore worthwhile attending. We suggest that a champion for this initiative be found from either inside or outside HMP Pentonville's Healthcare unit.

SHARING OF INFORMATION WITHIN THE SAFER CUSTODY FUNCTION

Inside HMP Pentonville, safer custody representatives meet on a daily basis. When meeting, consideration is given to incidents that have taken place in the preceding 24 hours and any action that needs to be taken. If there has been a self-harm incident, the Governor is informed as to the nature of the incident, updates to ACCT documentation are made and reasons why the self-harm took place are considered. If it was a serious incident, NOMS HQ will be informed.

Any emerging trends are discussed at monthly Safer Custody meetings. Consideration is given to incidents from the preceding month and what can be learned from any identified trends. Managers from all the residential areas of the prison attend these monthly meetings, as well as representatives from Healthcare, Security, Probation and Mental Health. Minutes of these meetings are circulated to every area of the prison.

Outside the prison, there are Safer Custody Forums attended by Safer Custody and Violence Reduction representatives from across the Prison Estate. There are also opportunities for Safer Custody Managers to get together at conferences, forums and meetings on other issues.

SHARING OF INFORMATION ACROSS SECTORS

The following sectors are implicated in this investigation: the Police Service, HM Prison Service and the National Health Service.

As far as the Police Service is concerned, we are satisfied that all relevant information relating to Mr Atlantic was passed over to the Prison Service via the PER [Person Escort Record form].

As far as the National Health Service is concerned, more information could have been made available to HMP Pentonville's Healthcare unit that might have helped in the prison's care of Mr Atlantic. Specifically, more detailed psychiatric information could have been provided by Barts and The London NHS Trust. Mr Atlantic's time there in hospital represented the largest proportion of time in one place. It would seem likely that a psychiatric assessment would have taken place, and with it, the opportunity to share this information with HMP Pentonville. Whilst IT systems such as SystemOne can help, there still needs to be a level of proactivity on the part of system users to obtain or pass on information. A high level of proactivity by the Barts and The London NHS Trust and HMP Pentonville Healthcare was not apparent in this instance.

To make better use of pre-existing information, we recommend that psychiatric assessment guidelines used on HMP Pentonville's Healthcare unit reference the need to source and consider the results of medical and psychiatric assessments that may have been conducted by other institutions.

CHAPTER 18. HOW EFFECTIVE WAS THE SUI INVESTIGATION?

The Serious Untoward Incident investigation report's⁷⁷ description of the background, context, incident, and its consequences were very much in line with our investigation findings.

The SUI report recorded that all patients were now being moved through an alternative route or lift where the risk was assessed as lower. By re-routing prisoner escorts, we feel that prompt and appropriate action was taken to address the physical risk.

The chronology of events appears to have been informed by the medical record only and not by staff interviews or with reference to the ACCT documentation. This includes the fact that the Healthcare Assistant who accompanied Mr Atlantic to the video-link didn't contribute to the SUI investigation beyond her initial written statement.

One Healthcare Officer does remember being called into the Head of Healthcare's office and asked if there was any way that the incident could have been prevented. This was the only example we heard of staff being involved in the SUI investigation. The fact that a very small number of those staff who came into contact with Mr Atlantic, either during or before the incident in question, were aware that a SUI investigation had taken place, further confirms that few staff were involved in its formulation.

This contributed to the fact that the investigation seems to have focused only upon clinical issues and staff. Whilst the SUI process is one laid down by the Department of Health, we feel the prison context should dictate that both discipline and clinical staff be involved in the investigation. For example, whilst the Charge Nurse was commended for her consistent efforts to engage with the prisoner, we would argue that it was one of the officers who achieved more in this respect.

A number of the issues identified through the course of this investigation were also identified through the SUI investigation. These issues included:

- poor EMIS admissions information and other record-keeping
- lack of up-to-date admissions protocol
- lack of communication between prison officer and healthcare staff

We acknowledge that the resulting action plan⁷⁸ does indeed seek to address these issues and that the recommendations made have been implemented or are in the process of being implemented. We feel that, whilst the recommendations do indeed seek to address the issues raised by the SUI investigation, a wider range of approaches could be used to help further influence staff behaviour. These approaches are aimed to go beyond the provision of training, circulation of memos and drafting of policy

⁷⁷ See Annex 11: Serious Incident Investigation report and action plan

⁷⁸ Ibid

documents; for example, they attempt to elicit, embed and sustain desired attitudes and behaviours.

Arrangements for shared learning were made in the SUI report. Specifically, it was suggested that the final report and recommendations be shared with all clinical teams at manager and operational grade, and with the prison Senior Management Team (SMT) and staff.

In fact, however, very few people with whom we spoke have any recollection of an internal investigation having taken place and only two interviewees recall having seen or heard of the ensuing report and its recommendations. This suggests to us that little was actually done to disseminate findings and learning. We see this as a missed opportunity to influence behaviour by helping people to see a clear rationale as to why changes to policies and procedures have been introduced. Knowing and understanding this rationale is more likely to influence behaviour in the desired direction.

DOCUMENTS REVIEWED BUT NOT ANNEXED

Assessment, Care in Custody and Teamwork: Care planning system used to help identify and care for prisoners at risk of suicide or self-harm

HM Prison Pentonville Suicide & Self-Harm Prevention Policy (2011)

Report of an article 2-compliant investigation into the circumstances surrounding the attempted suicide of D at HMP Pentonville on 27 December 2001. Stephen Shaw CBE, Prison and Probation Ombudsman for England and Wales. May 2008

PSI 18/2005 - Introducing ACCT (Assessment, Care in Custody & Teamwork)

PSI 38/2005 - NSF – Reporting in and Management of Potential Category A Prisoners

PSI 52/2010 – Early Days in Custody

PSI 64/2011 – Safer Custody

PSO 2700 – Suicide Prevention and Self-Harm (2007)

Report of an unannounced full follow-up inspection of HMP Pentonville, 24 February – 4 March 2011, by HM Chief Inspector of Prisons

Report of an announced inspection of HMP Pentonville, 11 – 15 May 2009, by HM Chief Inspector of Prisons

The Productive Ward. NHS Institute for Innovation and Improvement.