

**Report of an article 2-compliant investigation into the
circumstances surrounding the attempted suicide of D
at HMP Pentonville on 27 December 2001**

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This is my report of an Article 2-compliant investigation into the circumstances surrounding the attempted suicide of a man known as D at HMP Pentonville on 27 December 2001. I was commissioned to chair the inquiry by the Secretary of State further to a Court of Appeal decision in February 2006 regarding the circumstances of what the court called Mr D's "near suicide".

D was a 21-year old man who had been remanded to Pentonville on 30 November 2001, charged with common assault and threatening to destroy property. He had a history of self-harm and would try to harm himself several times while in prison. He made a serious attempt to hang himself on 27 December 2001, but was cut down and resuscitated by staff. Sadly, D suffered brain damage as a result of his actions and is unlikely ever to be well enough to return to the community.

Prison Service policy at the time of D's suicide attempt was not routinely to conduct an investigation following an incident of self-harm, although in D's case such an investigation was in fact carried out. However, in a landmark judgment, the Court of Appeal determined that this internal investigation was not sufficient to meet D's rights under Article 2 of the European Convention on Human Rights.

Accordingly, this was not just the first such investigation that I have been asked to carry out. So far as I am aware, it was the first such investigation into a near death in prison conducted anywhere in Europe. While the Court of Appeal had set out in broad terms how an Article 2-compliant investigation should be constituted, and how it should be conducted, I have not identified any precedents on which to base my work. To a very large extent, therefore, the practicalities of conducting such an investigation have had to be established as I have gone along.

It is likely that, in due course, Article 2-compliant inquiries will be required into many other incidents of serious harm in prisons. It is equally possible that some or all of this work will fall to my office. Certainly, it would sit well with my existing responsibility for investigating deaths in prisons, Approved Premises and immigration removal centres.

Whether that is the outcome or not, I have had it in mind whilst conducting this investigation that many will look to the procedures I have followed here in determining what is appropriate for analogous investigations in the future. I have considered some of the implications in the penultimate chapter of this report. In addition, I have attached in its entirety my opening statement to the public hearing I held in July 2007 at Annex A when I also reflected upon this issue. I do not claim to have got everything right – far from it. However, I have been guided by what I consider to be the principles of fairness, transparency, and an inquisitorial not adversarial approach. I have also learned a number of valuable lessons, and these too are set out in my opening statement and in the body of this report.

I have sought to adopt procedures that are proportionate and which provide proper value for money for the taxpayer. However, I doubt that I have

achieved either objective. The investigation took some 20 months to complete and its total cost (made up in very large part by the parties' legal bills) may well have exceeded £0.5 million. I believe this was disproportionate to the facts of this case. In any event, such a sum would prove ruinous were it to apply to all future inquiries into near deaths in custody.

My investigations as Ombudsman into deaths in prison are conducted largely without recourse to legal advice or oversight. But in this investigation into the case of D, the Prison Service was particularly concerned to safeguard its interests both in respect of any Article 2-compliant investigations that will follow and any criticisms that might be levelled as a result of my inquiry. It therefore instructed Treasury Solicitors in the matter. (It should also be acknowledged that my death in custody investigations are followed by a Coroner's inquest at which the Prison Service is routinely represented by Counsel.) To ensure that I was properly advised in my duties and powers, and to preserve the integrity of the investigation, I therefore deemed it appropriate to engage legal advice of my own. I am immensely grateful to Mr Laurance O'Dea of Treasury Solicitors (Solicitor to the inquiry) and to Mr Keith Morton (Counsel to the inquiry) for their help and advice.

Nevertheless, I regret the 'legalisation' of the whole process. It is largely responsible for the cost of the investigation and for the length of time it has taken (I had originally envisaged completing the entire investigation within six months or so of its commencement). To take just one example, because it wished to consult with its lawyers, certain information I requested from the Prison Service in November 2006 was not forthcoming until the following March. In a second Article 2-compliant investigation that I am now conducting – that into the care of SP whilst in Prison Service custody between 2003-2005 – I am endeavouring to simplify the procedures significantly.

Leaving aside its legal novelty, this investigation into D's attempted suicide posed a unique challenge in light of the passage of time since the event itself and the fact that very few papers relating to D's time at Pentonville survive. These two factors have been instrumental in shaping the investigation. Where I would ordinarily anticipate that an Article 2-compliant investigation into a near death would focus on the care of the particular individual, this has been less appropriate in this instance because of the absence of primary evidence and the fact that staff have (understandably) been unable to recall details about D's care. For that reason, my investigation has sought to establish the environment and regime that obtained at the time and to draw inferences about D's likely care from that more general information. It has also sought to determine the extent to which Pentonville has moved on since 2001 and, more specifically, whether lessons were learned as a result of what happened to D. However, this wider scope should not be taken as a precedent for future near death investigations. Those will all need to be shaped by the particular circumstances of the case.

I must conclude these words by making two further observations. First, I must thank all those who contributed to this investigation. I encountered a great willingness to assist despite the unprecedented nature of the inquiry and the

passage of time since the events which it considered. I was also shown great personal courtesy both by the witnesses and by those representing the parties. I am especially indebted to my colleague, Miss Ali McMurray, who assisted me throughout.

Second, I am conscious that those staff who saved D's life may, in part because of this investigation, feel at best ambivalent about their actions on 27 December 2001. They saved D's life, but he is permanently injured and will likely spend the rest of his life in care. No doubt those staff will ask themselves whether they did the right thing and will question whether they should act in the same way should the occasion arise again. Regardless of D's unfortunate condition, the answer must be an unequivocal yes. The saving of a life must be paramount.

Early on in the inquiry, I met Mr D himself and am conscious of the very serious damage he has suffered. I hope that this report properly reflects the State's obligations to him, and to other vulnerable people who come into the care and custody of the Prison Service.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2008

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TERMS OF REFERENCE

Having regard to the Court of Appeal judgment of 28 February 2006, to conduct an Article 2-compliant investigation into and report to the Secretary of State for the Home Department on the circumstances surrounding the near suicide of a young man (D) at HMP Pentonville on 27 December 2001. In particular:

- To establish the circumstances and events, especially as regards management of D by the Prison Service, including considering any information about how prisoners at risk of self-harm were cared for at Pentonville, and to consider relevant outside factors.
- To examine whether any change in operational methods, policy, practice or management arrangements would help prevent suicide and self-harm in Pentonville and other prisons.
- Where possible, to examine relevant health issues and to assess D's clinical care and consider any wider policy issues arising.
- To provide explanations and insight for D and his family.¹
- To examine the extent to which the recommendations of the earlier internal Prison Service investigation have been implemented.
- To consider the implications for future investigations into near suicides.

¹ For these purposes, all contact was via D's legal representatives.

A NOTE ON THE STRUCTURE OF THIS REPORT

This has been a lengthy inquiry and this is a lengthy report. It may be helpful, therefore, to provide a brief guide to its structure.

Following the summary, the report is divided into twelve chapters. In Part I, I outline what happened to D at Pentonville in the four weeks between his reception and being found hanging on 27 December 2001. Part II is a short chapter summarising the views of Counsel as to the critical issues the inquiry should consider. Part III looks at suicide prevention policy both nationally and at Pentonville, and Part IV considers how that policy was applied in D's particular circumstances.

Part V looks in detail at the events of 27 December 2001, including a phonecall that appears to have been the trigger for D's suicide attempt. This chapter also considers the assistance provided to D once he had been discovered.

Part VI is a second brief chapter that reviews the general state of Pentonville in late 2001. At rather greater length, Part VII considers the state of healthcare in the prison at that time. Part VIII focusses on the use of discipline staff in Pentonville's healthcare centre, and Part IX looks at mental healthcare both in general and in respect of D.

Part X looks at whether lessons were learned at the time from D's attempt on his life and the internal inquiry that was conducted. Part XI describes how I went about the inquiry and considers the implications for subsequent Article-2 investigations. I summarise my overall conclusions in Part XII.

A consolidated list of my recommendations concludes this report.

SUMMARY

Mr D was remanded to HMP Pentonville on 30 November 2001 on charges of common assault and threatening to destroy property. He had self-harmed at court that day and arrived at Pentonville from hospital on an open F2052SH.² He was located on a ward in the healthcare centre, but was moved to a single room the following day when he became violent.

He was assessed fully by a doctor on 4 December. She referred him urgently to both a forensic psychiatrist and a psychologist. The referral was repeated at various times, but, whilst D was seen by a psychologist on 18 December, it seems almost certain that he was not assessed by a forensic psychiatrist.

During the weeks that followed, D's behaviour and demeanour fluctuated. He went through relatively quiet periods but also had episodes where he smashed things up or self-harmed. On 13 December, he tried to hang himself. He was placed in a variety of locations under different levels of observations. However, instructions that he should be referred to the chaplain, the Samaritans and Listeners came to nothing.

On 27 December 2001, a broken razor blade and noose were found in D's cell during the morning. He also attempted to cover the flap on his cell door. After lunch, D smashed the locker in his cell. He was granted a phonecall on the office phone and found out that his young daughter had been taken into care. D was returned to his cell and a note was made in his F2052SH and in the observation book that staff should be vigilant. A short time afterwards, he was discovered hanging from a light fitting in his cell.

Staff cut him down after a short delay while scissors were brought, and they carried out resuscitation. An ambulance was called and D was taken to hospital. He suffered brain damage as a result of heart failure following the hanging and has remained in care ever since.

Suicide prevention procedures

National suicide prevention policy required a multi-disciplinary response to those identified as being at risk. Following identification of risk a support plan had to be drawn up to address the prisoner's particular needs. Regular case reviews, attended by a range of staff, were required to monitor the prisoner's progress. In addition, a record had to be kept of the prisoner's behaviour and mood.

Pentonville revised its local suicide prevention procedures during early 2001. The policy was comprehensive and detailed and wholly embodied the principles of F2052SH. Specific responsibilities under the system were allocated to particular grades of staff.

² F2052SH was a form used in the management of those at risk of self-harm or suicide. The term F2052SH is also used to apply to the policy governing the form. F2052SH has now been replaced by ACCT (Assessment, Care in Custody and Teamwork).

However, inspection reports on Pentonville by HM Chief Inspector of Prisons both before and after D's attempted suicide identified a number of concerns in relation to the administration of the policy. In particular, there was concern about the quality of entries on the forms, about the conduct and timing of case reviews and about staff training. These concerns were echoed by the prison's Board of Visitors (BoV).³

The strategy for managing those at risk of self-harm revolved largely around location, observation and support. A close examination of D's care at Pentonville showed that he was placed in a variety of locations – ward, single cell and anti-suicide cell at different times. I am critical that he was not given greater opportunity in the ward once his behaviour stabilised. I am also critical that D was placed in an unfurnished cell on three separate occasions, despite the use of such cells having been banned in March 2000. I judge that putting him there was likely to have exacerbated his state of mind. As far as observations are concerned, I note that it is likely that they entailed little engagement with D.

I am critical of the case reviews that were carried out; they were not multi-disciplinary and did not involve D himself. In addition, instructions arising from the reviews – for example, that D should be referred to probation, the chaplain and the Samaritans – were not actioned. I was unable to ascertain why this was or who specifically was responsible for implementation. Responsibilities for aspects of F2052SH that applied to residential staff did not translate to healthcare. I also suggest that little imagination was put into the support plans and that they did not address D's individual needs. In particular, they do not seem to have identified likely triggers to self-harm (for example, court appearances and bad news relating to his daughter) or what staff should do about them.

Nevertheless, it was clear that staff were very aware of D and were taking steps to manage him. I conclude that, generally speaking and while not ideal, the day to day care afforded to D was within the bounds of what was reasonable in prison healthcare at the time.

Since 2001, the Prison Service has substantially revised its suicide prevention strategy. I welcome the new policy which enhances assessment and care planning processes. However, any policy is only as good as its implementation on the day. In many of its fundamentals, the policy in operation with regard to D was similar to provisions under ACCT but specific shortcomings reduced its effectiveness. I make two recommendations aimed at keeping ACCT fresh and individualised.

Events of 27 December 2001

The nurse charged with observing D on 27 December 2001 was supplied by an agency and knew nothing about D beyond what she was told during the

³ Boards of Visitors were appointed to each prison by the Secretary of State to monitor conditions and the treatment of prisoners. They are now known as Independent Monitoring Boards.

handover. It is likely this was not much. I question the extent to which she would have been able to provide effective support.

I suggest that a manager should have interviewed D about the razor blade and noose found in his cell and that, notwithstanding that the finding of either was not especially uncommon, staff should have taken some action given the level of risk D was considered to present. I do not consider staff should have been particularly alarmed, however, either by D trying to cover his cell flap or by his smashing up his locker.

Allowing D to use the office phone was a kindness by staff aimed at addressing his anxiety and frustration. Had D possessed a phonecard he could have made a phonecall at any time, and it is important that all personal responsibility is not taken away from those at risk as this can diminish their sense of self-worth. I do not criticise staff in this respect.

I judge that there was time after the phonecall to take some action with regard to D and suggest that it would have been appropriate for staff to have done so. It was suggested during Ms Carole Draper's review of D's attempted suicide⁴ that cost may have been a factor in the decision not to place D on constant observations. I found no evidence of this. However, I conclude that simply making a written note that staff should be vigilant was an insufficient response following the phonecall.

The resuscitation of D was carried out professionally by staff who had been specially trained in trauma response on the personal initiative of Healthcare Senior Officer Peter Hayward who also led the trauma team. There was a slight delay whilst the scissors were brought, but in light of uncertainties over how long D might have been hanging I cannot say that the delay was significant in terms of D's complete recovery. The staff involved in the resuscitation should be commended for their actions.

Mr Hayward had initially been tasked with rolling out trauma training across the Prison Service. Given the importance of proper care immediately following a serious injury in preparing someone for treatment once he/she reaches hospital, the value of Mr Hayward's initiative was immense. Unfortunately, changes in healthcare provision in the Prison Service caused the initiative to fall by the wayside. I recommend that it is resurrected.

Healthcare

D was located throughout his time at Pentonville in the healthcare wing. This was a normal prison wing with few concessions made for healthcare needs.

⁴ Ms Carole Draper was a Senior Investigating Officer in the Prison Service's London Area office. She was commissioned to conduct a review of D's attempted suicide to determine whether a formal investigation was necessary. Her report fills many of the gaps left by the loss of D's records.

The centre was on the Prison Service red light⁵ in 2001 and had been roundly criticised by HM Chief Inspector of Prisons in 1999. The follow-up inspection in 2002 noted significant improvements but still expressed some concern.

Staff described the physical environment as dark and noisy. There was a large number of mentally ill prisoners, many of whom had complex needs. Turnover of prisoners was considerable. There appears to have been some staff shortage in healthcare during 2001 and considerable use was made of agency staff. They were briefed only for their particular task for the day and did not carry keys. The overall quality of staff appears to have been patchy. Regime delivery was hit and miss – time out of cell was variable and little was offered by way of purposeful activity.

Communication was not very effective, with a number of different documents in use pertaining to each prisoner. No single document contained the whole picture. There were also issues around storage and retrieval of documents, and medical records were not always to hand for consultations. Handovers were carried out between each shift but the information communicated was apparently quite basic and brief.

It is fair to assume that shortcomings in healthcare impacted on D's care.

That said, the investigation received evidence that healthcare at Pentonville has now been transformed. I saw the physical manifestation of this for myself when I visited the prison during 2007.

Solicitors acting for D were critical that decisions about D's location and level of observation were taken by discipline staff, when they should properly have been taken by clinical staff. My interpretation of the evidence was that authority for such decisions rested quite properly with clinicians but that staff had the power to react to given situations on their own initiative. This was entirely sensible. There were also concerns that authority for constant observations had to be given by a non-clinical governor grade. However, financial regulation is entirely proper in any environment, and no-one suggested that any clinical decisions to place someone on constant watch were overturned by the governor.

Mental healthcare

Following assessment on 4 December, D was 'urgently' referred to forensic psychiatric and psychological services. The referrals were repeated on various occasions and D was twice listed to see the visiting forensic psychiatrist. He was assessed by a visiting forensic psychologist on 18 December (which was remarkably prompt) but I conclude that he was never assessed by a psychiatrist (given the number of psychiatric provision in Pentonville, it is possible he was seen by a psychiatrist *en passant* but not for a detailed assessment). The systems in place appear to have been

⁵ That is, it had been assessed as in urgent need of remedial action under a 'traffic light' system whereby green meant the centre was performing satisfactorily and red indicated the opposite.

appropriate and provision was adequate. It has not been possible to determine why D was not in fact subject to a psychiatric assessment.

However, whilst it is clear that there was significant concern about D's mental health, it is not certain that he was in fact mentally ill. The opinions of two medical experts reviewing the available evidence were diametrically opposed on this score. This means that the failure to have D assessed (and treated) by a psychiatrist might or might not have been significant in terms of his care. I cannot make a judgement on whether D was in fact mentally ill and would therefore have benefited from the services of a psychiatrist. Manifestly, a psychiatrist might have made a difference. It is therefore impossible to view the failure to have D assessed as anything other than serious. In addition, the absence of a diagnosis in respect of his mental health meant that the psychologist could not formulate a plan.

The inquiry heard evidence that there is no longer any provision of psychological services for Pentonville. This means that care is now worse than it was several years ago. I recommend that the Prison Service seeks urgently to secure psychological services for the prison.

Learning lessons

Ms Draper made 11 recommendations as the result of her review. None of these was implemented at the time. The then Governor maintained that suicide prevention policies at the prison were good and that this was evidenced by internal audits at the time. The failure to follow up on Ms Draper's recommendations at the time is disappointing, albeit they have now all been implemented – largely as a result of other changes.

There is a clear value to investigating incidents of this sort in terms of the lessons that can be learned and the improvements made to policy and practice. I recommend that the Prison Service issues a new instruction that all suicide attempts and serious incidents of self-harm must be formally investigated. I also recommend that arrangements for storing the resulting reports should be in line with arrangements for other formal investigations.

Investigation

This investigation was severely impeded by the lack of contemporaneous documentation. However, I was able to draw on Ms Draper's report and transcripts of interview and also identified some documents that shed light on D's care. I interviewed a number of staff, some of whom had been interviewed previously by Ms Draper.

In light of the requirement for the investigation to be, at least in part, in public, I held seven days of hearings in London. In conducting these, I was concerned to ensure that the process was non-adversarial. I consider that I achieved this and that this was valuable in making this investigation as thorough as it could have been. I commend the approach as a model for further Article 2-compliant investigations.

In total, I have made ten recommendations.

PART I - SEQUENCE OF EVENTS AT PENTONVILLE⁶

Mr D

1.1 Mr D was born on 25 December 1979. A medical court report prepared on 31 July 2000 offers insight into his personality and background. He had a:

“... personality disorder of the emotionally unstable type, associated with poor impulse control. He has significant problems with alcohol and drugs (cannabis, cocaine and crack). He has been treated with anti-depressants whilst at Feltham YOI and had a tendency to self-harm.

“He clearly had a chaotic childhood with an alcoholic mother and absent father. There is a long history of conduct disorder at school, including stealing and playing truant. This behaviour started at Junior School and continued through secondary school. He has difficulties with literacy, which probably relate to his lack of schooling. Since 1995, he has a total of 11 convictions for 32 offences. These include theft, property offences, drug offences, offences relating to the police, courts or prison, and 1 firearms shot gun offence. He has had 10 custodial sentences.”⁷

1.2 A letter from Barnet, Enfield and Haringey Mental Health Trust in May 2002 described D as an ex-labourer from Clacton-on-Sea. It said he had a past history of alcohol abuse and that he said he drank ten cans of lager most days. The report went on:

“He is originally from Clacton-on-Sea. He had a difficult upbringing and his father left when he was very young. He attended a normal school but needed special teaching input. He did not know if he had been statemented. He left without qualification and became a labourer. There is a history of self-harming by cutting himself. He also had a positive forensic history with charges of theft and carrying a weapon. His mother died two years ago. He has no contact with his sister ... or his father. He has a one year old daughter ... who he has never seen. She lives in Clacton with his ex-partner from whom he has separated. He may be seeing his daughter for the first time later today, which he is pleased about. He has another girlfriend who occasionally visits him and also some rather disruptive friends who have visited him on the ward in an intoxicated state. In the long term he said he would like to return to work as a labourer and live nearer his daughter.”

1.3 The Prison Service Inmate Information System (IIS), a computerised database, shows that D had a significant custodial history, having spent periods at HMPs Parc and Chelmsford and seven (short) spells at HMYOI Feltham. A number of F2052SHs were opened as follows: 17 November

⁶ D's core record, his inmate medical record (IMR) and sundry other documents that would have shed light on his time at Pentonville have been lost. This section draws on what contemporaneous documentary evidence survives. It is supplemented by Ms Draper's report.

⁷ In fact, for the vast majority of his periods in custody, D was on remand.

1998 – 26 January 1999, 27 August – 15 September, 22 September – 15 October 1999, and 19 June – 11 July 2000. He cut his wrist at Feltham with a plastic broken cup on 19 June 2000 causing a wound of sufficient seriousness to warrant (outside) hospital treatment.

1.4 At the time of his remand to Pentonville, D was 21⁸ and, as noted in the medical court report above, had a baby daughter with his girlfriend. He had been known to his local mental health services before his entry into Pentonville for severe drug abuse, potential self-harm and actual self-harm.

Staff recollections of D

1.5 It is sad, if unsurprising, that few of the staff at Pentonville who gave evidence (including those who had attended him following incidents of self-harm) could recall D. Pentonville was at the time the busiest prison in Europe, with large numbers of people coming and going on a daily basis. Some prisoners would be at the prison for only a matter of days before being released or being taken to another prison following a court appearance. There were undoubtedly staff shortages at the time and this militated against staff getting to know prisoners well. D was at Pentonville for less than a month. It is perhaps telling in itself that, despite his manifest problems – his repeated self-harm, his poor mental health and his substance misuse – he did not stand out from the crowd.

1.6 Dr Vasantha Ranaweera was the doctor to whom D was allocated on his arrival at the prison. She told the inquiry she had no recollection of him. She confirmed that, from the documents available, it seemed D presented no differently from a lot of patients with whom she had dealt.

1.7 Two members of staff did remember D. Prison Officer Peter Richards described D as very up and down and demanding. Nothing was ever right for him – he wanted a cigarette or the person opposite to be moved or slippers or whatever. He said it was always “want, want, want”, although D did have his calm moments. Mr Richards said D was irritating but he could talk to him more than some of the other patients in the healthcare centre, as he was not on such heavy doses of medication. During a preliminary interview, Mr Richards said prisoners were allowed radios in their cells, but he could not recall if D had one. D was not a reader and he could not recall him having any particular friends on the wing. Mr Richards said he did not think D would kill himself.

1.8 Mr David Leane, who was a prison officer at Pentonville during 2001, told the public hearing that D had “definitely stood out”, but said he never had

⁸ Sir David Ramsbotham, then HM Chief Inspector of Prisons, recorded in his 1999 report of an inspection of Pentonville that just 5.4 per cent of the population was aged 18 – 21 years, whilst 19.2 per cent was aged 22 – 25 years. His successor as Chief Inspector, Ms Anne Owers, recorded in her 2002 inspection report that 23 per cent was aged 21 – 24. This can only afford some indication of the prisoner age profile in December 2001 (not least because of the different age ranges used by the two Chief Inspectors), but it does suggest that D was comparatively young amongst Pentonville’s population.

a problem with him although he could be violent and abusive towards staff. He confirmed that when D first arrived at Pentonville his arms had been in a “terrible state”. He agreed that D had originally said staff could not stop him from self-harming, but thought D had got better whilst he was in healthcare. Mr Leane said he was not involved in D’s care and did not have many conversations with him, although D did come to Mr Leane’s attention more than some others. Mr Leane said D was a poor copper and would smash up his cell when he could not manage. He thought it might have been frustration as much as anything. He imagined D was demanding of staff, although he did not ask Mr Leane for anything. Mr Leane could not remember whether D had many visits or whether he associated particularly with anyone on the landing. He thought he might have undertaken some education on the wing.

Arrest and remand

1.9 According to Ms Draper’s report, D was remanded to HMP Pentonville on 30 November 2001, charged with common assault and threatening to destroy property.⁹ He had been held overnight in police custody on 29 November 2001, arriving at court the next day with a Prisoner Escort Record (PER) indicating existing injuries and marked for self-harm/suicide. On his arrival at court at 9:45 am, Securicor personnel opened an F2052SH and placed D on a 15 minute watch. At 12:45 pm, after his court appearance, D was found to have further injuries that required hospital treatment. He was discharged from hospital at 3:50 pm and thereafter taken under constant observation to Pentonville.

At Pentonville¹⁰

1.10 A Register of F2052SH has an entry (no. 2012) for D. It notes that he was placed on an F2052SH before he arrived at Pentonville and that the form was opened by an L Skinner at Thames Magistrates’ Court at 9:45 am on 30 November 2001. Nothing is recorded under “Nature of self-harm?” A computer generated record of those on F2052SH shows that the form had been raised as the result of “staff concern”.

1.11 A photocopy of the healthcare diary¹¹ entry for 30 November noted that D and two other prisoners were to see Dr Ranaweera after 5:00 pm. Next to the names has been written, “See list on Monday 3/12/01.”

⁹ These charges were discontinued by the CPS following D’s admission to hospital on 27 December 2001. However, Ms Draper (who had access to D’s prison file) listed his offences as attempted theft, possession of an offensive weapon, threatening behaviour and ABH. A Discharge Summary from the Royal Free Hospital dated 23 July 2002 said D was remanded for brandishing a knife in the street. It said he had at first been thought to be a danger to others but it was later decided that he was threatening only to harm himself.

¹⁰ So far as possible, I pieced together details of D’s time at Pentonville from such contemporaneous records as could be found. Where information is gleaned entirely from Ms Draper’s report without corroboration in any of the records I have seen, this is signalled in the text.

¹¹ My colleague, Miss McMurray, asked for the actual diary but it could not be found.

1.12 The Draper report said D arrived at Pentonville at 4:25 pm. He was assessed in reception and admitted to the healthcare centre on an open F2052SH, and was also given an alcohol detoxification prescription. D was found to have deliberately self-harmed on both arms. He told staff he felt very depressed due to the break up of his relationship with his girlfriend who was pregnant by his friend, and that he felt hopeless about the future. D was admitted to the shared ward facility, ward 3, and referred for an urgent assessment by medical staff. Dr Ranaweera saw him at 5:30 pm and referred him to the visiting psychiatrist. Ms Draper said that the referral was itself marked "Urgent" and double underlined.

1.13 A healthcare observation book entry for 1 December recorded:

"Apparently reported by ward staff that D was presenting threatening behaviour and being disruptive in the ward. D was apparently attempting to throw a chair through the window of the ward office. [Illegible – possibly 'Orderly Officer'] informed and staff assisted to remove D to AS3 pro-tem. Spoken to D. He seemed miserable and was moaning about his move to AS3. Positive support and counselling given to him."

Action to be taken was:

1. Refer to duty doctor.
2. 15 min doc watch pro-tem
3. Assess mental state a.s.a.p.
4. Review further care and management."

1.14 Further details of the incident were provided in a resulting prison disciplinary charge laid against D on 3 December 2001 for using threatening, abusive or insulting words or behaviour. They said that at about 2:30 pm in close observation ward 2, D picked up a chair and attempted to throw it towards the window pane of the nurses' office, aiming it at the reporting officer and another PSN (Prison Service Nurse). The report to the Governor said D continued to display threatening and abusive language and behaviour, telling the reporting officer that she should watch herself. D continued to point his fingers at her repeatedly.

1.15 The Draper report said that, later on 30 November at about 6:10 pm, D threatened to self-harm with a pencil, but remained quiet the rest of the night and following day.

3 December

1.16 The observation book recorded on 3 December that D was:

"Seen in his cell, re-opening a cut on his left arm made previously. Says he will kill himself by Friday next, before he has his court

appearance. Also threatening to harm staff and his ex-girlfriend. Spoke about getting a gun to shoot others with or using a knife.”¹²

He was to be referred to Dr Ranaweera.

1.17 The Draper report said D was duly seen by Dr Ranaweera that day and a full history was taken. D acknowledged that he had a history of self-harm, and had previously been in a Young Offender Institution but this was his first time in an adult prison. He admitted to a heavy alcohol habit. He said that he had lived with his girlfriend for two and a half years and had a child by her. He was anxious and seemed to have multiple superficial lacerations to both arms, but was not considered actively suicidal nor clinically depressed. An urgent referral was made to the visiting clinical psychologist for counselling and a visiting psychiatrist for a mental assessment as well as to the chaplain, Samaritans and Listeners.¹³

1.18 The Draper report suggested that the psychiatric referral was actually made on 30 November. However, an entry in the healthcare diary for 3 December lists D as the first of six prisoners to see Dr Ranaweera before 5:00 pm. An additional comment says “seen – ref Psychiatrist”. (Interestingly, four of the other five prisoners were similarly referred.)

1.19 The referral for Psychiatry/Psychology form itself was dated 3 December. It showed D’s index offence as possession of an offensive weapon. It listed the reasons for referral as:

1. “Alcohol abuse
2. P/H [past history] mental illness. Referred to St Clement’s Hospital in recent past
3. H/O [history of] self-harm and on F2052SH. Violent behaviour at times – smashed two cells
4. Relationship problems.”

¹² It may be of significance that D self-harmed at court on 7 December 2001 and the day before his court appearance on 14 December. He was also seen throwing things round his cell the day before his court appearance on 20 December. He was due back in court on 27 December (though this was presumably altered because of the Christmas holidays).

¹³ An (incomplete) manuscript note by Ms Draper of entries in D’s IMR (possibly made after 14 December) showed that D reported previous custody for violence and possession of a weapon and had been placed on constant watch at Thames Magistrates’ Court on 30 November. He had been taken to Whitechapel Hospital and a F2052SH opened. His offence was recorded as being in possession of a sheath knife in a public place without good reason. The F2169 (reception screening form) noted that D had previously been on Prozac and Diazepam and had deliberately self-harmed a “few years ago”. He had used cannabis two weeks previously but denied any current drugs use. He said he drank seven or eight cans of super strength lager daily and had no previous psychiatric history. It was noted in the IMR that D had previously self-harmed by cutting both his left and his right wrists and had attempted suicide by jumping in front of a bus. There was no concern from outside agencies. D was currently on Diazepam and said he felt suicidal and liable to self-harm. The doctor assessed him as very withdrawn and extremely anxious. D had walked out on his girlfriend, who was pregnant by someone else and he felt depressed. He told the doctor he was suicidal, clinically depressed but not mentally ill.

The referral ended:

“For urgent assessment by Clinical Psychologist for counselling.”

The form was marked ‘Urgent’ at the top, underlined twice (suggesting that it was the one Ms Draper said was completed on 30 November), and a box was ticked to show that the degree of urgency was within one week (the alternative offered on the form was one to two weeks). It said D was aware of the referral.

1.20 Ms Draper also reported that D self-harmed at 9:40 am by stabbing himself in the arm with a knife and threatened to kill himself. (It is not clear whether this was before or after his interview with Dr Ranaweera.) He later settled and took part in association that afternoon.

1.21 However, the observation book recorded on the same day that:

“At approximately 19:45 hrs Officer [Paul] Parry was informed that HD7369 D had obscured his observation panel. Officer Parry attended the cell (H1 – 09) and attempted to enter, but D had placed a chair between the bed and the door creating a barricade. Officer Parry forced the door open, and we gained entry. D held an item to his throat. Officer Parry and myself took the item away from him. He had cut both forearms.”

The observation book shows D was attended by healthcare staff and re-located to ward 3.

1.22 An incident report by Officer Parry said:

“At approx. 19:45 hrs on H109 I removed a T shirt blocking the observation hatch to find HD7369 D had self-harmed by cutting his wrists (both arms) and a small cut to R side neck. I removed the barricade by force and entered the cell. I took charge of his arms to prevent him harming himself any more. D then dropped a small piece of porcelain which he had used to harm himself. I sat him down on his bed with PO Gillan and administered First Aid. D has been moved to ward 3.”

The form was annotated to show D had not been placed on a disciplinary report.

1.23 An IRS (Incident Reporting System) report was raised. This recorded that D had lacerations to both forearms and a small cut to the right side of his neck and that the incident had taken place in a single cell in the healthcare centre. It said D was not on medication at the time (this was probably incorrect) and did not require resuscitation. He was on an open F2052SH.

1.24 The Draper report said that, at 9:15 pm on 3 December, D was seen by a doctor who prescribed some medication and referred him urgently to the visiting psychiatrist.¹⁴

4 December

1.25 An entry in the observation book for 4 December said:

“Inmate [D] moves from ward 3 to H1 AS3. Kicked toilet unit which fell apart. Placed on report and moved to H1 – 24. Seems to have calmed down however still claims he will harm himself given the opportunity.”

1.26 Mr Richards said at the public hearing that he assumed D was moved from ward 3 to the AS (Anti-Suicide) cell because he was being disruptive again or had created a problem of some sort. However, Ms Draper’s report said that this happened at 9:40 am and that D was moved “after once again self-harming”.¹⁵ She said he was described (she did not say where) as “hysterical, agitated and unco-operative and he claimed he could hear voices that were telling him they were going for his daughter.”

1.27 Another (untimed) entry in the observation book for the same date and by the same officer (Richards) said:

“Inmate’s behaviour deteriorating. Becoming paranoid. Hearing voices. Dr Yisa [Dr Mahazu Yisa, the senior medical officer] saw inmate. Administered medication. Compliant throughout.”

1.28 Ms Draper said D was seen by Dr Yisa who sedated him and placed D on a documented 15 minute watch. Dr Yisa requested an urgent referral to a psychologist and psychiatrist.

1.29 A further entry in the observation book read, “I.M. medication given today. Dr Yisa’s inst do not give any further meds today or tomorrow the 4 & 5 Dec.”

1.30 Ms Draper reported that, at 11:00 am, D was due to attend an adjudication (a prison disciplinary hearing). I obtained the adjudication papers. The section on the paperwork for certification by a medical officer recorded that D was not fit for adjudication on 4 December because had been medicated at 11:00 am. He was also not fit for cellular confinement as he was awaiting psychiatric assessment. The adjudicator recorded that D was unfit to plead.

¹⁴ Dr Ranaweera had completed a referral form earlier in the day. Neither Ms Draper nor I have discovered a second referral form. It is possible the doctor realised that a referral had already been made.

¹⁵ I note that this was the same time as D had self-harmed the day before. I have no way of knowing whether this is coincidence, a developing pattern or a mistake over dates by Ms Draper.

1.31 Nevertheless, a conduct report on D had already been prepared in advance of the hearing. It said D's conduct was less than satisfactory and that he was demanding and abusive. He was unemployed and on the standard level of the Incentives and Earned Privileges Scheme.

1.32 The Draper report said that, during the morning of 4 December, a case conference was held. It was attended by medical and nursing staff. D was placed on one-to-one watch for at least the next 24 hours. A further urgent referral was made for assessment by a clinical psychologist and a psychiatrist.¹⁶

1.33 Ms Draper reported that, at 12:00 midday, D ripped off dressings from both arms and told staff he did not want to live. He was assessed by a doctor who maintained him on a one-to-one watch and noted that he was awaiting assessment by specialists. Ms Draper wrote, "Thereafter he appears to have slept."

1.34 A second record of an adjudication showed that D was charged at 6:00 pm on 4 December with destroying or damaging any part of a prison or any other property other than his own. The details of the charge were that at about 8:45 am on 3 December in AS3 cell, D damaged prison property by kicking the toilet side panel until he had broken it.

1.35 Dr Halsey, visiting forensic psychologist, replied to Dr Ranaweera's referral on 4 December. It appears to be a standard letter. Dr Halsey advised that he had received the referral on the previous day and that it was intended that most referrals would be seen within one month of the date received.

5 – 12 December

1.36 The disciplinary charge laid on 4 December was due to be heard on 5 December. The section of the record entitled Certification by Medical Officer showed that D was unfit for adjudication because he had had to be injected and was too drowsy. The adjudicator noted that the prisoner was "unfit only for today. Opened in his absence."

1.37 D was listed to be seen on 5 December by Dr Akinkunmi, a psychiatrist, but was not seen. I do not know whether Dr Akinkunmi did in fact attend the prison on the date in question as the gatebook entry for that day could not be found. (It is possible that he did visit but did not see D because he was still too drowsy from the medication.)

1.38 Ms Draper reported that D was due a legal visit on 6 December, but this was cancelled because he was not feeling well. At this stage he was due to be observed once an hour. A case conference was held during the day. The view was apparently that D was more settled, although Dr Yisa had seen him because he had been banging his head.¹⁷ Ms Draper wrote that D was

¹⁶ See note 12 above.

¹⁷ This appears contradictory.

very low in mood during the early evening and said he was anxious about his daughter “and everything taking place in his life”. At 6:15 pm, he was seen to rip up a bed sheet, which he attempted to conceal but handed over when asked.¹⁸

1.39 An IRS report for 7 December said D had been found at court with blood on both arms. First aid was administered and the cell was searched. A small piece of tile board was found. D confirmed he had used this to self-harm. The form recorded that D was not on medication and not on an open F2052SH (though someone has written in manuscript that IIS stated one had been opened on 30 November), and that resuscitation was not required.

1.40 Ms Draper noted that D had removed dressings from both of his arms earlier on at court (that is, before the blood was discovered). After self-harming, he was seen by the Forensic Medical Examiner at court. Ms Draper said it was also recorded (she did not say where) that D told staff they would not stop him self-harming if he could not see his daughter.

1.41 An observation book entry for 7 December said:

“Returned from court very tearful & complaining of ‘lock jaw’.
Procyclidine given and Dr to review. Inmate also self-harmed in court using porcelain tile from bathroom.”

1.42 Ms Draper reported that D was more settled following his return, but was seen by a doctor on 8 December and kept on a one-to-one watch.

1.43 According to records from the Royal Free Hospital (who had apparently had access to D’s Inmate Medical Record (IMR)¹⁹), D had been on 10 mg of Diazepam per day, but this was stopped on 9 December. (The hospital noted that at the time of the suicide attempt on 27 December, D was awaiting psychiatric opinion and was on 37.5 mg of Ventafaxine and 50 mg of Chlorpromazine per day.)

1.44 The disciplinary charge for damaging his cell was re-issued to D at 3:45 pm on 9 December. On 10 December, a doctor signed the form to say that D was fit for adjudication (he did not mention fitness for cellular confinement). The adjudicator recorded that he had adjourned the hearing for a medical report. He wanted to know whether D was in a fit state of mind at the time of the offence.

1.45 The conduct report prepared for this hearing recorded once again that D’s behaviour was “less than satisfactory” and that he had been moved from ward 3 because he was abusive to staff.

¹⁸ Mr Richards told the public hearing it was very common for prisoners to rip up sheets in order to use them for ‘lines’ (that is, a means of passing items from one cell to another). However, it is worth noting (even if staff at the time did not) that D was due to appear in court the next day. He had said on 3 December that he would kill himself before his next court appearance.

¹⁹ The hospital reported to me that it no longer had the record.

1.46 Ms Draper's report said that a case conference was held on 10 December. D was regarded as far more settled, with no suicidal ideation. The F2052SH was kept open but the level of watch reduced to 15 minute-documented.

1.47 Ms Draper said a further case conference was held on 11 December and the level of watch 'reduced' to 15 minute-supported.²⁰ D was also referred to the education department.

13 December

1.48 Ms Draper reported that, on 13 December, there was a further case conference. D was considered to have settled well and not to be clinically depressed or suicidal. It was proposed to relocate him to a normal shared cell.²¹ The F2052SH was to remain open and he was to be assessed by the visiting psychiatrist and psychologist. A support plan and discharge report was drawn up in the F2052SH.

1.49 However, an entry in the observation book for 13 December said:

"Brought in from exercise wanting to see me. Asking me to give him something to help him sleep through the day – when advised as to my position – demanded to see a doctor – inmate informed all doctors unavailable due to clinical meeting – started throwing his furniture around the cell and [?citing] verbal abuse of a highly charged and sexual nature."

Written alongside the entry is, "(What action is being taken?)"²²

1.50 A later entry said, "At approx 13:55 this man was found hanging by PSN Abani. Alarm raised and D was saved." It was recorded that D was seen by Dr Yisa and placed on one-to-one supervision.

1.51 An IRS form recorded that D was in a single cell on ordinary location [sic], was not on medication at the time and was not on an open F2052SH (although someone has again written in manuscript that IIS stated one had been opened on 30 November). Resuscitation was not required. (Another report recorded that he had used a piece of bed sheet.)

1.52 The F213 Report of Injury to Inmate form for 13 December²³ recorded that at 13:55:

²⁰ Dr Ranaweera explained at the hearing that, although support was not stipulated in a 15 minute-documented watch, support was in fact provided through the need to engage with the patient to make notes of his condition.

²¹ Since there were no shared cells in the healthcare centre, I take this to mean that D was to be discharged from healthcare and moved to a normal wing.

²² In his evidence, Professor Rogers noted the inconsistency between the finding of the case conference and this report of D's behaviour.

²³ Although the Incident Reports referred to here show that an F213 was completed on each occasion, this is the only one to have survived.

“Whilst carrying out a landing check during the landing patrol, D was observed to be hanging from his cell window. Alarm raised. Cell entered. Cut down. First aid given. Seen by SMO.”

The Medical Officer’s report on the same form recorded that the doctor examined D at 2:00 pm. He wrote, “Found hanging. No injuries.”

1.53 The Draper report said D was seen by Dr Yisa who placed him on a 15 minute documented watch (this differs from the note made in the observation book) in a semi-furnished cell and referred him to Listeners, the Samaritans and probation. She noted that there was a suggestion in one document that no F2052SH was open at this time.²⁴

14 – 26 December²⁵

1.54 All the following information about D for the period from 14 – 27 December (with the exception of the extract from Dr Halsey’s letter) is drawn from the Draper report. She does not state what her sources were.

1.55 On 14 December 2001, D attended Thames Magistrates’ Court and was remanded to appear at Southwark Crown Court on 20 December. He returned to Pentonville to cell AS3 (semi-furnished) on a 15 minute documented watch until he was seen by a doctor.

1.56 On 15 December, he was relocated to a single cell (R1-21). He remained settled and interacted with staff and other prisoners.

1.57 At about 3:00 pm on 16 December, D had a period of head banging, telling staff he was missing his daughter. However, he calmed down and went on association.

1.58 On 18 December, D had a social visit.²⁶ A case conference was held at which the view was that he was not mentally ill or clinically depressed. He was anxious but not actively suicidal. A decision was made to keep him in the healthcare centre for mental observation on a 15 minute supported watch and to continue the F2052SH.

1.59 On the same day, D was seen by Dr Robert Halsey, a clinical psychologist. Dr Halsey advised that his meeting with D had been:

²⁴ I presume this refers to an IRS report. It is difficult to determine its importance. A number of IRS reports said D was not on an open F2052SH, so it might simply have been a recording error. However, it may be significant that a case review that morning had concluded he was no longer at risk and could be discharged.

²⁵ At this point, a number of pages were missing from my copy of the observation book extract. The copy was found with papers provided for court proceedings that led to the establishment of my inquiry. It is possible that only those pages considered relevant (because D was mentioned) were copied. This might suggest that D came much less to the attention of staff during this period. However, I cannot be certain of this. I asked for the original book, but it could not be found.

²⁶ I wrote to D’s visitor at the address recorded for her, but did not receive a reply.

“... largely unproductive, as he was largely preoccupied with providing me with details of the break-up of his relationship with his girlfriend and relaying the stress that this caused to him. He repeatedly returned to the theme of wanting to die and his attentions [sic] to kill himself.

“He also reported suffering from auditory hallucinations in which he hears the voice of his ex-girlfriend telling him to kill himself which he told me he had acted on in the past, for example by throwing himself under a bus, and also jumping into the River Thames from Woolwich Pier. He told me that whilst an in-patient at the Royal London Hospital approximately three months ago, he cut his wrists.

“D told me that he also suffers from nightmares in which he hears people shouting at him. He said that for this reason he is frightened to go to sleep.

“D denied using any illicit drugs during the past two years, although admitted to drinking up to four cans of strong lager per day. He also denied any prior psychiatric history, although he told me that he had been seen by a psychiatrist when serving a sentence in HMP Feltham approximately two years ago. D told me that he has prior convictions for a number of ‘car’ related offences, and also theft and assault.”

Dr Halsey said he had intended to continue his assessment in the New Year and would be happy to do so if D returned to the prison.

1.60 In the event, the letter (to Dr Ranaweera) was not sent until 25 January 2002 (that is, almost one month after D’s suicide attempt and over five weeks after the consultation).²⁷ Dr Halsey said it was his practice, however, to provide initial feedback in the IMR and face to face to the allocated doctor.

1.61 Dr Halsey formed the opinion that D’s presentation indicated a need for psychiatric evaluation (this is at odds with the findings of the case review the same day). Ms Draper noted that Dr Halsey listed D to be seen the following day. If he could not be seen for any reason, he was to be included on the list for the visiting psychiatrist at the earliest opportunity.

1.62 At 12:00 midday on 19 December, D was seen throwing things in his cell but would not say why. He was listed to be seen by Dr Akinkunmi, but in the event I conclude he was not seen.²⁸ He was apprehensive during the night about his court appearance the next day.

²⁷ Dr Halsey told me he had not immediately been told about the suicide attempt, although he clearly knew about it by the date of this letter. His normal practice was not to write such a letter until such time as he had completed his assessment.

²⁸ I have not been able to establish why this was, as the gatebook shows that the Dr Akinmunmi attended the prison on that day between 10:15 am and 10:45 am. (Of course, this was a very short period and only a small number of patients could have been seen in such a short time. It is also possible that Dr Akinkunmi planned to see D, but this was not thought appropriate because of his behaviour.)

1.63 On 20 December, D attended court. Over the following days, entries in the F2052SH apparently suggested he was in a congenial mood and interacted well with staff and other prisoners.

1.64 On Christmas Day,²⁹ it seems D called out to another prisoner at about 4:45 pm that he was going to die that night. He reportedly told staff he was not alright but would not say why.

27 December 2001

1.65 Ms Draper reported that, during the morning of 27 December, a routine cell search revealed a broken razor blade or blades and a noose in D's cell.³⁰ D said that the former was for cutting matches and the noose was intended as a joke.³¹ The discovery was reported to a senior member of staff. The nurse undertaking observations of D said he kept blocking the observation hole and she had to ask him not to do so.

1.66 An observation book entry by SO Hayward for 27 December noted that D:

“Became abusive and aggressive this afternoon & smashed his locker – claiming he couldn't stand being banged up any longer.”

In the section of the book detailing action to be taken, SO Hayward wrote, “No further action.” Mr Hayward explained at the public hearing that by this he meant that no disciplinary action was to be taken against D.

1.67 Ms Draper timed this entry at 3:00 pm. She said furniture was removed from D's cell as a precaution and that Officer Leane agreed with SO Hayward (who was in charge of in-patients for the day) that D could be given a phone call in the hope that it would calm him.

1.68 Mr Leane remembered D asking him for a phonecall on the morning of 27 December, but did not recall what he said at the time and did not know the reason D wanted one. Mr Leane promised D he would arrange a call for him, but then went off the wing for a while. When he returned, D had smashed up his cell. He assumed that D must have asked someone else about his phonecall in his absence, and that they must have given him a different response or told him that he would have to wait for Mr Leane. Mr Leane still

²⁹ As well as being Christmas Day, this was D's 22nd birthday. I infer from the context in Ms Draper's report that an entry was made in D's F2052SH about this.

³⁰ Unfortunately, she does not say where this was recorded.

³¹ The find was recorded in the observation book, but without any indication of the exact location. Mr Richards said at the public hearing that he would normally record where he had found the items referred to and acknowledged that it was a poor entry that did not help anyone. He surmised that he must have found the articles in empty cells and did not recall finding a razor or noose in D's cell. He could not remember where he did find them. Ms Draper does not say where she got her information about the items being found in D's cell. However, the detail she provides tends to substantiate what she says. The ambiguity is unhelpful, however, in assessing later actions.

allowed him his phonecall, telling D that if he (Mr Leane) said he would do something, then he would do it.

1.69 At the public hearing, Mr Leane said he could not remember promising D a phonecall, "but I obviously did". He said he returned to the landing at about 2:00 pm. He could not recall if he said anything to D about his having smashed up his cell.

1.70 Mr Leane said he told D some time between about 2:00 pm and 2:15 pm to calm down for ten minutes and that he could then have his phonecall. Mr Leane was present throughout the phonecall. (He explained at interview that D did not have a phonecard and was therefore allowed to use the official phone.)

1.71 He remembered D talking after the call about having "lost" his daughter, but realised during conversation that she had been taken away by Social Services. (He said at interview that D was tearful and distressed after the call.) He said he took D straight back to his cell, as there was no association at the time. Mr Leane said at interview that he spoke to SO Hayward who noted the heightened risk in the observation book. Mr Hayward wrote:

"Given phone call. Apparently his child has been taken into care by Social Services – already on 15 min watch – staff need to be vigilant."

He also recorded "F2052SH noted" (by which he said he meant that a corresponding entry had been made in that document).

1.72 Mr Leane explained to the investigation that it was not unusual for prisoners to have bad phonecalls, but D was vulnerable and he thought Mr Hayward needed to be aware. He added, when asked, that it was not part of his job to refer to the doctor or suggest a move to a ward. He had discharged his responsibility by speaking to Mr Hayward.

1.73 During preliminary interview, Mr Hayward said he was sitting in the office when Officer Leane went back past with D and locked him up. Mr Hayward said there was nothing untoward about D's behaviour and he was not crying or screaming and shouting. He said that, if he had been, he (Mr Hayward) would also have gone to the cell in case he was needed. He said that, straight after locking up D, Officer Leane went to the office and told him (Mr Hayward) that D had had a bad phonecall.

1.74 The agency nurse, Ms Phoebe Chikuku, told Ms Draper that she had about six people on 15-minute watch at the time and that D had repeatedly blocked the spyhole during the day. She had seen D about ten minutes before discovering him hanging. She said D had gone to use the phone and did not want to speak when he came back. However, he did not appear low or distressed, but was the same as he had been in the morning. She said a neighbouring prisoner told her subsequently that D had had a telephone call with his girlfriend. When she went to D's cell about 30 minutes after he

returned from making his phonecall, there was newspaper over the flap. She removed it and saw D hanging. Ms Chikuku said she pressed the alarm and called for help. She said no member of staff had told her about the telephone call. She explained what happened next as follows:

“Then when I came back again after ten minutes, there was a newspaper on the flap and I just take the newspaper off then I saw D hanging himself. I called for help, I called for scissors and [pressed] the alarm – that’s when the crew came in.”

1.75 Officer Richards noted in the observation book that at 3:45 pm:

“Inmate found hanging from light fittings. Staff entered cell. Supported his weight. Cut down. Airway put in. CPR commenced. Paramedics arrived also air ambulance. Stretched out. Breathing and a pulse without aid when he left.”

1.76 Three of those involved in the resuscitation (Officer Leane, Officer Doug Murray and Healthcare Senior Officer Hayward) completed incident reports. These were respectively as follows:

- “Agency Nurse alerted me that D HD7369 had blocked his spyhole. When entering the cell he was hanging from his light unit. Eventually when he was cut down we started to work on him. Ambulance turned up at 16:00. They took over.”
- “I was making my way back to H1 landing when Gov Clark said that something was happening. On arriving on H1 landing I saw people standing at H1 – 18. On entering the cell I saw inmate HD7639 D hanging from the cell light. I took D’s weight (body) onto my shoulders. He was then cut down and we started to carry out CPR after checking A.B.C.”
- “Sir – At the above time, date and place [15:45 pm, 27 December, R1 – 18] I responded to an alarm on R1 landing – HD6685 [sic] D was hanging suspended from his ceiling cell light. We supported his weight whilst he was cut down. I inserted an airway into him and commenced CPR as breathing and pulse were absent. He was connected to a defibrillator which showed a rhythm of asystole. I administered a pre-cordial thump which then produced a weak output. Officer Murray continued chest compressions whilst I continued to ventilate him with an ambu bag. Paramedics arrived on scene and a paramedic intubated him whilst I (?obtained) venous access. Dr Khan administered 1mg of adrenaline intra cardiac and then the HEMS³² helicopter team arrived. D was now showing a cardiac output. He was secured on a scoop stretch and by the time he left the establishment he was breathing for himself.”

³² Helicopter Emergency Medical Service.

1.77 At the public hearing, Mr Richards said he was not actually working on the 1s landing on the afternoon of 27 December, but might have gone there simply to pick up something. He recalled that there was usually a lock down³³ on Thursday afternoons for staff training. Mr Richards did not remember reading Mr Hayward's entry.

1.78 Mr Richards said the nurse had waved him over, but he did not know why. He said he ran over because he thought something was up. He looked in the cell (the observation panel was clear) and saw D hanging. He opened the door and went straight in. He thought it was about ten seconds before the others arrived. Mr Leane was trying to get the noose off, but it was very tight. A bag containing ligature cutters was flung from the door. He said everything happened in a flash and that they put D on the floor.

1.79 During preliminary interview, Mr Richards said he entered the cell straightaway and took hold of D's legs to support his body weight. Mr Leane stood on the bed and tried to remove the noose (both men were members of the Hotel 9 team³⁴). He said the ligature was well made, using the hem of a bed sheet (that is, where it was double thickness). Mr Richards said it was very tight to D's neck, so it was very difficult to get the scissors under. He said D must have planned the attempt in advance as the ligature was fed through the light fitting.

1.80 He said they placed D on the ground. He had urinated and was blue in colour. Mr Richards said he thought he was dead. The defibrillator was brought in and an airway fitted. Someone called an ambulance, but Mr Richards could not recall whether a doctor came. The HEMS helicopter arrived and intubated D. He was then placed on a spine board and put on the pool table outside the cell to give people more room to work on him. Shortly afterwards, D started coughing and rejected the airway (this is a positive sign as it means the patient's reflexes are working). An anaesthetic was administered.

1.81 Mr Leane told the public hearing that the nurse first drew attention to the fact that D's cell hatch was covered. He thought the time between D being returned to his cell and the nurse saying that the hatch was blocked might have been between 30 and 45 minutes. He said it was quite common for prisoners to block their hatches in order to gain some privacy. It was not an unusual occurrence for a nurse to report and was therefore not an emergency at that stage. He thought that the nurse might simply have shouted and that he was in the central office when she did so. He could not recall who was first at the cell. It was only once the door was opened that they found D hanging.

1.82 During preliminary interview, Mr Leane said that, when he went into the cell, D was hanging from the light fitting in the middle of the room. (He

³³ When all prisoners are locked behind their cell doors.

³⁴ Hotel 9 is a prison call sign. It is used here to refer to an initiative to train a team of staff in trauma techniques to enable them to respond effectively and professionally to medical emergencies throughout the prison.

explained that the light fitting in D's cell dropped down from the ceiling – it was not embedded in the concrete.) D had passed the ligature (a bedsheet) over the top of it.) D's feet were high off the ground and he had obviously used the bed to stand on. Mr Leane got on the bed to try to release the ligature, but it was pulled very tight by D's weight. Mr Leane could not release the ligature from the fitting or get it off D's neck. Officer Richards was holding up D whose head was completely floppy. Mr Leane remembered shouting that if someone did not bring something to cut him down, D would die.

1.83 He said they administered mouth to mouth and chest compressions. He also thought they intubated D and that Dr Khan might have given him a shot of adrenaline. He could not recall any issues around Dr Khan's role.³⁵ Mr Leane said D was in a very bad way and appeared dead. He said that, if it had not been for Mr Hayward, he would have been. The prison relied heavily on him at the time in relation to trauma response.

1.84 Mr Murray told the inquiry that he could not recall what he was doing at the time but that he and a governor, Mr Clark, were just seconds away from D's cell. He said he could not recall how the alarm was raised, he just responded to something Mr Clark said. Mr Murray said he went to the cell and that D was hanging from a light fitting in the middle of the cell. He helped to get him down and administered CPR. He said all the necessary equipment was readily available, including the defibrillator.

1.85 Mr Hayward said at the hearing that the alarm was raised as he put his pen down after writing the entries in the observation book. He said he ran into the cell to find two officers holding up D from the floor. He jumped on the bed. All four staff present supported the body, but Mr Leane was unable to remove the ligature. Mr Hayward shouted to a nurse to fetch the scissors. She went away and came back to say she could not find them. He said they were in the emergency bag. She asked where that was and he told her. She fetched the bag and then threw it into the cell. Mr Hayward had to get down off the bed to retrieve the scissors from the bag.

1.86 Mr Hayward explained that Dr Khan looked into the cell, saw that resuscitation was being carried out and left. The duty governor shouted for him to return. Mr Hayward thought the doctor might have said that they seemed to be doing okay - he was at the door and then he was not. Mr Hayward confirmed that he (Mr Hayward) was in any case already preparing to administer adrenaline himself.

1.87 During the preliminary interview, SO Hayward said that he thought they had a good chance of reviving D, as he could not have been suspended for that long. They got him down and laid him on the floor, inserted an airway and began chest compressions. They tried the defibrillator, but it gave a reading of 'No shock required'³⁶. A doctor looked in on them but started to

³⁵ It was suggested to Ms Draper that Dr Khan looked into the cell but then started to move away.

³⁶ That is, there was no need to re-start D's heart artificially, as a heart-beat had been detected

leave. Mr Hayward asked for him to be called back. Mr Hayward said that, even though they were well trained, it was always good to have a medic on the spot who could take charge. In addition, although he was trained to give venous access (to enable drugs to be administered), he could not do so because he was giving chest compressions.

1.88 Mr Hayward said other staff just left them to it. He explained that not all nurses, nor even doctors, are trained in trauma. Nevertheless, he felt unsupported. However, he added that staff were distracted by the prisoner in the next door cell who was threatening to kill himself.

1.89 Mr Hayward said the ambulance was called and HEMS turned up. He could not say how quickly it arrived. The ambulance staff intubated D.

1.90 Governor Clark wrote a report for the Governor the following day. He said Nurse Chikuku found D hanging at about 3:48 pm and called for assistance from nearby staff. He said he raised the alarm himself on arrival at the scene at 3:49 pm. He then requested an ambulance at 3:51 pm. The ambulance arrived at the prison at 3:58 pm, with the crew arriving on scene at around 4:00 pm, where they were briefed by SO Hayward. At 4:02 pm, Mr Clark was informed the air ambulance was on its way and deployed fixed posts to allow the helicopter to land in the prison grounds if necessary. The ambulance landed outside in Roman Way at 4:04 pm with the crew arriving at D's cell at 4:08 pm. Mr Clark said that, by this time, D was showing cardiac output. He was then secured on to a scoop stretcher and removed from the cell on to the landing where additional medical work was carried out. At this stage, D was breathing for himself. The ambulance left the prison at 4:24 pm, with two staff escorting D.

1.91 Mr Clark said that he was called at home at 8:30 pm and advised that D's condition had deteriorated and that the hospital had suggested contacting the next of kin. Mr Clark instructed the Night Orderly Officer to do so.

1.92 The timing of events was recorded separately on the prison's Radio Log and the Command Suite logging sheet:

15:49 - Alarm - "Alarm h'care assistance reqd"
15:51 - call from 'V' to 'JP' - "Ambulance req 1 inmate hanging CAD 2143
15:53 - O3 to JP - "Incident resolved. Rtn prison to normal except h'care"
15:58 - Info - "Ambulance arrives RW"
16:02 - Info - "Ambulance dispatching helicopter. V informed"
16:04 - Info - "Man fixed posts"
16:24 - C1 to JP - Inmate leaving by ambulance to Royal Free
19:10 - B/W to JP - "Off Whittaker 'D' b/watch AOK"
20:00 - B/W to JP - "Off Whittaker inmate 'D' move to third floor recovery ward"
20:15 - B/W to JP - Off Whittaker - Has next of kin been informed - going for brain scan"
20:35 - JP to V - "As above gave him number of inmate"

The Command Suite logging sheet was as follows:

16:04 - "Air ambulance crew arrive. Man fixed posts"
"Each of the fixed posts reported in position between 16:05 and 16:07"
16:07 - "Air ambulance crew entered via R.way and escorted to Healthcare"
16:10 - "Police confirmed they will patrol outer wall"
16:25 - "Inmate to go to Royal Free"
16:25 - "Fixed posts to stand down"
16:33 - "Ambulance leaves establishment with inmate"

1.93 The Night Orderly Officer's report showed that he ascertained D's next of kin details and contacted the police to ask them to attend and inform the person named of the situation. The Night Orderly Officer then described his contact with the Prison Service's Area Office and Press Office. He recorded that he contacted the hospital at 9:15 pm and was told staff escorting D had accompanied him to a CT scanning area. The Night Orderly Officer contacted the bedwatch officer at 9:50 pm and was told that the scan had indicated a neck injury. D had been induced into a semi-comatose state (for his safety) by the medical team who would review the situation depending on his progress during the night.

D's current condition

1.94 I visited D at the unit where he was a detained patient on 26 July 2006. He is a severely disabled young man. His limbs were contorted as he sat. He endeavoured to engage with me but his speech was very poor. This was evidently a source of much frustration to him. It was clear from a mixture of his speech and his cradling gestures that he was desperate to see his daughter. Staff at the unit said he approached mothers with babies when he was outside. (Sadly, if he were ever to see his daughter, he would probably not recognise the young girl as the baby he keeps in his mind.) Staff also reported that he still seized all opportunities to try to kill himself.

PART II - THE ISSUES

Opening statements

2.1 At the start of the July public hearings, Counsel of the inquiry and each of the parties set out the issues to be explored by the investigation. In this short chapter, I outline what they said.

Counsel for the inquiry (Mr Keith Morton)

2.2 In his opening statement, Mr Morton set out details of D's time at Pentonville. He noted that D self-harmed or threatened to self-harm on at least 12 occasions. He was referred to the visiting psychiatrist six times, but was not seen by him. Neither was there any record of referrals to Listeners, the Samaritans and probation being followed up. The trigger for D's attempted suicide on 27 December was distressing news about his daughter, and yet concern for her had been the trigger for previous threats to self-harm. Mr Morton said that steps taken to protect D proved ineffective and that it was for the investigation to consider why this was.

2.3 Mr Morton described the principal features of the Prison Service's strategy for preventing suicide. This included training for all staff and the introduction of a structured plan for support and care for those identified as at risk. Pentonville's own document required weekly multi-disciplinary case reviews (which were to include the prisoner), a support plan, and personal officer (or key worker).

2.4 Mr Morton noted the introduction of a new national policy for caring for those at risk of self-harm, but said the investigation would need to consider whether there were further lessons that could be incorporated arising from this inquiry into D's attempted suicide. He added that improvements made at local level should be assessed in light of HM Chief Inspector of Prisons' most recent report on Pentonville.

Counsel for D (Ms Kristina Stern)

2.5 In her written opening statement, Ms Stern said the purpose of the investigation was to ensure that all facts were carefully scrutinised, all responsible were made accountable and that lessons should be learned for the future. Ms Stern argued that the investigation should not be "beguiled into refraining from expressing critical views on the basis that systems had changed and improvements made". She pointed to a number of criticisms in HM Chief Inspector of Prisons' 2006 report on Pentonville which echoed shortcomings at the time of D's suicide attempt.

2.6 Ms Stern said issues arose as to the adequacy of the psychiatric care provided by the Prison Service. She also referred to reported shortcomings with healthcare at Pentonville at the time, and suggested that some requirements of Standing Order 13 (the Order governing healthcare arrangements) were not met. Ms Stern inferred that there were a number of

areas in which the system failed to take all reasonable precautions against the risk of self-harm.

2.7 Ms Stern suggested the investigation should consider the following points:

- screening at reception and the apparent failure to access all possible sources of information about the prisoners;
- lack of clear communication and availability of medical records;
- failures in care planning;
- clinical input into decisions as to the prisoner's accommodation;
- responsibility for determining levels of observation;
- the role of non-clinical staff in caring for prisoners in healthcare;
- continuity of care;
- failures in the system of referrals;
- training in mental health and suicide awareness;
- the role of the suicide prevention team in learning lessons;
- the regime;
- the non-availability of ligature cutters.

2.8 In her oral statement, Ms Stern argued that it was necessary for the investigation to look at the whole chain of causation in relation to D's attempted suicide. In this connection, she suggested that the inquiry might wish to consider whether D's injuries could have been less severe or preventable if action taken to cut him down had been quicker.

2.9 Ms Stern said that one of the purposes of the inquiry was to learn lessons and that, in so doing, it was valid to use the benefit of hindsight. She added that D's clinical care should be assessed by reference to the care that would have been provided by the NHS outside prison and against standards, policy and actual care obtaining at the time. She asked that the investigation consider whether there was some blurring of clinical and discipline functions in the healthcare centre at Pentonville. Ms Stern also noted that, despite apparent improvements, HM Chief Inspector had found that only one of ten specific recommendations relating to self-harm and suicide had been fully implemented and that deficiencies reflected those evident in D's care.

2.10 Ms Stern referred to some of the policies and procedures of the time. She said there was a requirement for healthcare staff to have a good working knowledge of current instructions and guidance on suicide prevention, and that they should bring to the attention of the senior medical officer any concerns relating to risk of self-harm so he could manage the prisoner's care. In addition, all those at risk should be cared for in ward or shared accommodation unless clinically contra-indicated. The doctor should also be advised about any bad news to be communicated to the prisoner. She said this did not happen in D's case.

2.11 According to Ms Stern, it was clear that D demonstrated many of the characteristics identified in Pentonville's suicide prevention policy as

suggestive of a potential for self-harm and that there were clear indications he was mentally ill. He had auditory hallucinations and had previously suffered from depression. Nevertheless, Dr Yisa concluded he had emotional rather than mental problems. In addition, the care plan was not implemented. Ms Stern said that much could have been done to forestall D's attempted suicide during the weeks leading up to 27 December 2001.

2.12 Referring to what happened that day, Ms Stern noted the finding of the noose and razor and suggested that D's behaviour was similar to what it was before his previous attempt to hang himself. She noted that the decision on how to respond to D's phonecall was made by someone who acknowledged having little previous knowledge of him.

2.13 Ms Stern asked the investigation to look at the identification of risk during reception, the medication prescribed to D, poor communication and record keeping, the effectiveness of handovers, communication of outcomes from the care reviews, lack of follow up to the care plan, decision-making in relation to D's location and level of supervision, systems of referral, training in suicide awareness, the role of the suicide prevention team and the regime in healthcare.

Counsel for the Prison Service (Mr James Eadie)

2.14 Mr Eadie said the Prison Service deeply regretted D's attempted suicide and that systems and procedures had been reviewed and altered. He suggested that the changes reflected the fact that the Prison Service took very seriously its responsibilities with regard to suicide prevention. There was a danger of inferring too much from investigations into deaths at around the same time as D's attempted suicide, and Mr Eadie suggested that criticism of individuals should form no part of an Article 2-compliant investigation. He emphasised the importance of learning lessons from what had been done well as well as from what had not.

2.15 Mr Eadie described the poor conditions in the healthcare centre at the time of the arrival of Mr Gareth Davies as the prison's Governor, and the steps taken by Mr Davies to improve matters.³⁷ As a result, concerns about staff commitment and care had been dealt with by the end of 2001.

2.16 Describing steps to manage D's risk of self-harm, Mr Eadie suggested that D's risk had reduced by 14 December 2001 to such an extent that consideration was given to closing the F2052SH. A period of instability until 19 December was then followed by a period where D "appeared much calmer and participated fully in the regime".

2.17 Mr Eadie inferred from the available evidence that the time lapse between D being returned to his cell and being found hanging was ten minutes or less. As such, he argued, there was no time for the various staff concerned to take any action.

³⁷ Mr Gareth Davies took over as Governor at Pentonville in June 2000.

2.18 Mr Eadie submitted that it was, “no exaggeration to say that the prompt action and professionalism of all those involved in the immediate reaction to the alarm saved D’s life.” He also referred to Mr Hayward’s personal commitment and professionalism in undertaking trauma training himself and then providing it to others.

2.19 He said it was by no means certain that D was not seen by probation, the Samaritans or the Listeners, but acknowledged that, if he was not, he should have been. Likewise, he acknowledged that D should have been seen by a psychiatrist, but noted the lack of documentary evidence to show whether or not referrals were followed up.

2.20 On documentation, Mr Eadie acknowledged the importance of systematic recording and storage of information but suggested that any shortcomings in this respect did not impact materially on events. In addition, systems had been reviewed and a new electronic system was about to be introduced.

2.21 Mr Eadie then described various changes at both national and local level in relation to suicide prevention policy and arrangements and healthcare.

2.22 In his oral statement, Mr Eadie again expressed the Prison Service’s deep regret at D’s attempted suicide and re-stated its commitment to minimising incidents of self-harm.

2.23 Mr Eadie warned against the dangers of hindsight. He said the fact that D attempted suicide was not of itself evidence of a failure in systems or by individuals. He said the purpose of the investigation should be to establish what happened, and whether what happened should have done, and whether anything should have happened that did not, bearing in mind the nature of the population at the prison. He said the inquiry should consider what lessons there were to be learned and whether those lessons remained relevant today. Mr Eadie made a distinction between individual and state responsibility with regard to D’s care.

2.24 Mr Eadie said there had been significant changes in national suicide prevention policy and in healthcare provision at Pentonville. However, it was not the task of the investigation to conduct a full blown review of the present day system; nor was it appropriate to consider in depth other incidents that occurred at about the same time as D’s suicide.

2.25 Finally, Mr Eadie emphasised that the investigation was not a civil trial of negligence. It was not appropriate for it to engage in criticism of individuals. However, it was right that the inquiry should give due weight to things that had been done well.

PART III - SUICIDE PREVENTION POLICY

National policy

3.1 At the time of D's attempted suicide, national suicide prevention policy was embodied in Instruction to Governors (IG) 1/1994. (Technically, this had expired in March 1999.)

3.2 Some of the aims of the strategy were to:

- create a safe, humane and positive environment for prisoners and staff;
- encourage supportive and trusting relationships;
- help prisoners to see ways of coping better with their problems; and
- provide activities and choices which reduce isolation and depression and build self-esteem.

3.3 Key standards were that:

- all prisoners were to be assessed for suicide risk on reception at the prison, taking into account any information accompanying the prisoner;
- a Self-harm at Risk Form (F2052SH) was to be opened and the relevant procedures followed for all those about whom staff were concerned. Those identified as at risk were to be seen by a medical officer within 24 hours, but management of suicidal prisoners was not necessarily a matter for healthcare staff. Unit managers were responsible for co-ordinating action to address the prisoner's individual needs, "including the provision of any necessary support and supervision, consulting and involving other staff disciplines, outside agencies, the prisoner and his/her family as appropriate";
- where the prisoner was admitted to healthcare, the doctor was to ensure in-patient care in accordance with Prison Service healthcare standards;
- at-risk prisoners were to be located in shared accommodation wherever possible unless it was not considered to be in their best interests or their behaviour was too disturbing to other prisoners;
- residential and patrol staff were to be informed about at-risk prisoners at shift handovers;
- all relevant information about at-risk prisoners was to be documented, including assessments, instructions, observations of the prisoner, support by staff or others and information received from the outside;
- the needs of the prisoner were to be kept under regular review by staff, in consultation with the prisoner;
- a Daily Supervision and Support Record was to be maintained; and
- the F2052SH was to accompany the prisoner everywhere.

Local self-audit of suicide and self-harm procedures – 2001

3.4 Pentonville carried out a self-audit of its suicide and self-harm procedures, probably during early 2001 (the forms available are not clearly

dated). This concluded that of 21 baselines, nine were non-compliant. A note dated 16 March 2001 recording the findings reported that there was a lack of local instructions and that, although these were being developed, they did not seem to be generally available to staff. Procedural failures that resulted in F2052SH documents not being correctly monitored were noted, although the writer also reported that the documents were checked daily by the duty governor and, as a consequence, the general standard of comments was good. Nevertheless, most of the documents checked either had not been correctly opened or had not been reviewed within the prescribed timescale. Over 200 staff had been trained in suicide awareness in 2000 and the general standard of knowledge amongst staff was good. However, there were still some staff who had yet to receive initial training or who had not received refresher training: "As a result of this some basic errors are being made that could have dire consequences." The note concluded that the nine baselines with which the prison was not compliant could be quickly rectified, that the audit had identified several areas of good practice and that the attitude of staff to suicide and self-harm was "very professional".

3.5 Worksheets apparently relating to the same audit noted that there were various undated policy statements and it was difficult to work out which one was current. In addition, there was at that time no local policy document.

3.6 Some of the shortcomings revealed by the audit were as follows:

- no Samaritans and Listeners posters on C wing;
- although copies of local instructions were in every landing office, only one member of staff had seen the full policy document (although the majority had seen the policy statement as it was on the walls in most areas);
- healthcare staff did not always attend Suicide Prevention Management Team meetings and residential staff were often poorly represented. It was recommended that an operational manager should attend;
- the acting suicide prevention co-ordinator chaired meetings in the designated leader's absence. This was considered not to be good practice and it was recommended that the Head of Residence or Deputy Governor should chair in those circumstances;
- the most recent meeting was the first at which incidents of self-harm were discussed and minutes were "very scant";
- the Incident Reporting System did not include every incident of self-harm;
- the SPMT [Suicide Prevention Management Team] did not formally monitor F2052SHs. It was recommended that an auditable report on the quality of F2052SHs should be submitted to the team by the suicide and self-harm co-ordinator;
- "very few" case conferences were held within 72 hours of the F2052SH being raised, case conferences were often late, were "rarely" multi-disciplinary, "hardly ever" held following an incident of self-harm and not always held before closing the form. In addition, residential staff rarely attended healthcare case conferences;
- there was no key caseworker job description;

- PER³⁸ forms were not seen by healthcare staff or the doctor;
- F2169As³⁹ were not always completed, especially for change of status and transfers in – doctors did not see these categories of prisoners;
- agency nurses in both reception and the healthcare centre had not been trained in suicide awareness.

3.7 An (unfortunately undated) note referring to recommendations arising from the audit reported that the prison’s training plan had allocated a ten-week slot between November 2001 and January 2002 for suicide prevention training. It said that 252 staff had been trained, including 80 per cent of those working on the detoxification wing: “This was carried out as a priority as most self-harm was happening on that unit.”

Local suicide prevention policy

3.8 A Principal Officer was appointed in early May 2001 solely to work on suicide prevention and anti bullying⁴⁰ and a revised local suicide prevention policy document was published (probably during summer 2001). The then Governor, Mr Davies, told the inquiry the impetus had been the performance of local prisons in relation to suicide prevention, notwithstanding that Pentonville was one of the best. He said they simply had to do something.

3.9 The policy statement said:

“Caring for at risk prisoners

All staff at HMP Pentonville are committed to identifying prisoners at risk of self-harm or suicide.

Through care and understanding we will provide a safe, humane and positive environment for prisoners.

It is our duty actively to protect prisoners from acts of self-harm or suicide whilst preserving their individual dignity.

We will support, care and meet the needs of those prisoners who self-harm in order to prevent further acts of self-inflicted injury and suicide.”

³⁸ Prisoner Escort Records (PERs) accompany prisoners outside prison and contain key information about them.

³⁹ Reception screening forms.

⁴⁰ In a note to the Governor dated 14 January 2002, Ms Liz Meade, (then) Board of Visitors wrote:

“... he has written the Suicide Prevention Policy, implemented a system of case reviews so that finally case reviews are happening and on time, and the quality of suicide prevention work has been acknowledged to have improved.”

(Ms Meade was concerned that plans were afoot to divide the work between six Senior Officers on D wing, “with more man hours for the task but not one designated person”.)

3.10 The introduction to the statement advised that the document launched several new procedures. These were:

- Job descriptions for everyone involved in the process of managing and caring for vulnerable prisoners and in particular for those on the F2052SH system;
- A formalised system of case conferences to ensure that prisoners on F2052SH were being actively managed;
- An action plan outlining steps to be taken in providing a greater degree of support to suicidal prisoners;
- Principal Officer to take on the role of Suicide and Violence Prevention; and
- The tightening of procedures and in particular the “**management checks and standards expected of managers running this system.**” [Bold in original.]

3.11 The Suicide Prevention Team was to comprise the Head of Throughcare, the Suicide Prevention Principal Officer, each of the residential and operational governors, residential managers (at Principal Officer level where they were on duty) and representatives from the Samaritans, Listeners, probation, psychology, education, chaplain, Securicor, Board of Visitors and the library. The standing agenda would consist of self-harm incidents, F2052SH procedures and quality checks, Listeners and Samaritans, systems and procedures and promotion of support to vulnerable prisoners.

3.12 The policy instructed that any person who identified a prisoner at risk of self-harm or suicide could open a F2052SH – the prisoner did not actually have to have self-harmed. It was the responsibility of all wing staff to identify prisoners on a F2052SH. Unit managers would allocate a key worker to every prisoner on an open F2052SH and the prisoner had to be informed who this was. Wing staff had to be aware of the prisoner’s needs from the Support Plan, and at least one entry every day had to record how the plan had developed. All interactions were to be recorded in the Daily Supervision Record, with an entry made every two hours unless closer supervision was necessary.

3.13 Each wing was given a weekly slot for case reviews and the duty governor was responsible for ensuring these took place at the allotted time. Key caseworkers were to provide a report on the prisoner and ensure that the support plan was followed, reporting any difficulties to unit managers.

3.14 F2052SHs were to accompany prisoners everywhere.

3.15 The F2052SH had to remain open for at least 48 hours and could only be closed following a case review at which all relevant parties and agencies were present. It was the responsibility of the unit manager (not the medical officer) formally to close the form.

3.16 Reception officers and healthcare staff were to assess all receptions for suicide risk using standard screening procedures and information from the

PER form. A doctor was to see all first receptions, change of status prisoners and transfers in.

3.17 A First Night Centre was to receive all new prisoners and those whose status had changed, and staff there were to provide higher levels of support during the earliest part of imprisonment. The Listeners scheme was to be part of the induction process and 'new prisoners' would be introduced to them. (The document set out details and requirements of the Listeners scheme.)

3.18 Finally, the document established the respective responsibilities of Principal Officers, Senior Officers and basic grade officers in relation to suicide prevention. The requirements of Principal Officers and, in particular Senior Officers, were detailed and prescriptive in relation to implementing and monitoring systems and documentation. Principal Officers were to check and sign daily all open F2052SHs on their wing, and ensure that case reviews took place on time and a key caseworker was appointed. Senior Officers' responsibilities replicated those of Principal Officers in some respects, but were even more detailed. They were also to be responsible for initial decisions on managing the vulnerable prisoner, following through on support plans and determining the frequency of subsequent reviews.

3.19 Officers were instructed to check open F2052SHs when coming on duty as a matter of routine.

Suicide prevention practice

3.20 In the course of preliminary interviews, staff were asked about how those at risk of suicide were managed at Pentonville.

Responsibilities

3.21 Healthcare Senior Officer Hayward described to the hearing his responsibilities in relation to those at risk. He said he checked the documents, made sure he was familiar with the prisoners, checked any incidents, provided information to staff during morning briefings and checked the board for those on F2052SHs. He went to see any who appeared on the board whom he did not know. Mr Hayward said he also checked F2052SHs to ensure that case reviews had taken place.⁴¹

3.22 Officer Richards said he had seen Pentonville's 2001 suicide prevention policy, as it was pinned up in offices and dotted around the place. However, he did not recall being briefed about the particular responsibilities of residential officers. Nevertheless, he would be alert to prisoners' mood changes, make sure he was aware of the relevant support plan and check any open F2052SHs.

⁴¹ In fact, local policy gave the task of ensuring case reviews had taken place to the Principal Officer. It was the job of the Senior Officer to ensure that ensuing support plans were implemented. (Mr Hayward pointed out at the hearing, however, that this allocation of duties related to residential staff.)

Training

3.23 In her report into D's suicide attempt, Ms Draper said that some Pentonville staff had not received suicide prevention training for several years. She noted that the position had improved in preparation for an audit, but stressed that training should be made available to agency nurses.

3.24 It was difficult for those interviewed for my investigation to recall training they might or might not have received some five or more years previously. Some remembered receiving suicide prevention training "on occasion". Those who did so thought the training focussed largely on completion of the F2052SH, although there was some training on identifying risk. Mr Hayward suggested that healthcare staff were sufficiently experienced to recognise risk without the additional training. Nevertheless, the fact that about 90 per cent of new receptions had a history of psychiatric illness, or drugs or alcohol misuse was constantly stressed to staff.

3.25 He said he thought suicide awareness training was a half or one day course. He could not recall doing it himself. There was a rolling programme of refresher training, for which staff would be called up on a Thursday afternoon. He thought staff were very comfortable with the mechanics of the F2052SH procedures and they would be happy to open forms when they identified the need.

3.26 Mr Richards did not recall any training in relation to the F2052SH beyond his initial officer training. However, he acknowledged that it was possible that he had simply forgotten because there was nothing exceptional about it. He said staff were dealing with F2052SHs on a daily basis. Personally, he was comfortable with the process and knew what his responsibilities and those of others were. He also said he was "probably" trained in recognising indicators of possible self-harm. The training on mental health issues provided by the Royal Free Hospital would also have covered it. In short, Mr Richards said he could not recall what training he had had in suicide prevention, but knew he had had it. He said a lot of it was common sense.

3.27 Mr Leane told the public hearing that he "imagined" staff had been trained in the use of the F2052SH. He said he was not aware that any member of staff could raise the form but that in any case he had no occasion to. He could not remember having had any training in recognising signs of possible risk and was not aware of the need to report all instances of self-harm. Nevertheless, he said the F2052SH was taken very seriously.

3.28 Mr Leane said he had never seen Pentonville's suicide prevention policy. He acknowledged that he was a residential officer, and said he was aware of the bullet points in the policy relating to daily checks and entries. He suggested it was a matter of common sense rather than training.

3.29 Nurse Chikuku said she had had no training from the prison. The only instruction she received was from the agency. This involved a general

discussion rather than formal training. She was told about the F2052SH and about documenting observations and the purpose of the form. She did not recall being told how to open the form.

3.30 She was familiar from her college training with working with people at risk, but it was new in terms of actual experience. Nurse Chikuku did not recall being told about risk factors, though she knew from friends that there was a higher risk of self-harm in local prisons. However, she did not know that those aged 21-30 were at greater risk, or that those with mental disorders or who were detoxing were at raised risk.

3.31 Nurse Chikuku said she had seen the suicide prevention policy in the nursing station, but had not had time to read it. She confirmed that staff were encouraged to read it if they got the chance.

Accommodation

3.32 The investigation learned that by December 2001 all the cells in the healthcare centre were single occupancy. In addition, there was a ward on R2 and two anti-suicide cells. Dr Yisa told the hearing he was keen on wards and had worked hard to get three introduced. He said attempted hangings in wards were rare and successful attempts were non-existent. Wards offered a better option than constant observations. However, two of the wards had been closed (he implied without proper consultation with him) so that the space could be used for workshops.

3.33 Dr Ranaweera explained that those patients who needed to share were placed in the dormitories. However, this was only possible if they posed no threat and did not disrupt other patients. She told the hearing that, in locating a prisoner, it was necessary to think about other prisoners as well as the likelihood of self-harm. If there was no risk to others, ward 3 was the best option as the ward set-up facilitated observation and interaction.

3.34 Mr Hayward said the wards were used for those at risk of suicide. A nurse was deployed there constantly and would watch the prisoners through a screen. Prisoners were effectively on constant observation. One-to-one watches could be inhumane and intrusive and detrimental to the prisoner's self-esteem. The ward was a sort of halfway measure and provided the prisoner with others with whom to interact.

3.35 Mr Hayward explained that those at higher or more active risk of suicide tended to be placed on R1 landing. This was because it was not good for other prisoners on the ward to see a prisoner self-harm and it could be intimidating for the nurse to enter the ward if there was an incident. Because the ward was better for interaction, removal to R1 was a last resort. Those on R1 were less closely supervised than those on the ward, although the doors on R1 were open for the majority of the day.

3.36 SO Hayward went on to say that there were other problems with the wards. Two (on R1) were closed due to bullying.⁴² In addition, the ward was not appropriate for those requiring constant supervision because there were blind spots (for example, the showers) and some incidents had occurred there. Mr Hayward said the use of the wards was always a bit controversial, but his own view was that the ability to interact outweighed the disadvantages.

3.37 We asked a number of witnesses about the use of the anti-suicide cells at Pentonville.⁴³ Dr Yisa said he did not “believe in them”, but Dr Ranaweera told the hearing the anti-suicide cells were not routinely used and were temporary measures when the patient was very disturbed. They enabled the prisoner to calm down and be observed. She described the cells as helpful in managing those at risk of self-harm since they ensured the patient remained physically safe. In contrast, a normal cell would contain large sheets and the prisoner would also have his shoelaces. In her evidence, Nurse Vicky Japaul also said she was very much in favour of the anti-suicide cells. They were a means of keeping the prisoner safe in the short term.

3.38 Mr John Attard, formerly a healthcare principal officer and subsequently a governor grade, confirmed that the anti-suicide cells were used only as a last resort but said there was nearly always someone in them. SO Hayward said they tried not to use the special cells but agreed that quite a lot of use was made of them at times, although the aim always was to keep the prisoner there for the minimum time possible. Mr Hayward advised that the cells were not in fact very safe. They served simply in the interim whilst staff talked to the prisoner and calmed him down. Quite often the prisoner was merely frustrated and expressed this through violence. If staff could de-escalate the situation they could make progress. Prison Service Nurse (PSN) Tony Smith also said the semi-furnished room was used a lot.

3.39 Mr Leane told the hearing the time a prisoner remained in the cells varied from one hour to (in one instance he recalled) four months, and that prisoners in the AS cells were not given association because they were a problem. Nurse Shirley Boateng, on the other hand, advised that the use of the AS cells was reviewed every two hours and prisoners did not remain in them long.

3.40 The former Governor, Mr Davies, said he was not very happy about the anti-suicide cells. Staff used them as crutches – it was the only solution that sprang to people’s minds. He did not like their use. They presented as safe

⁴² This is different from Dr Yisa’s account of why they were closed, but the two might not be mutually exclusive.

⁴³ Anti-suicide cells (also known as strip or stripped cells or as semi-furnished cells) were cells designed to keep vulnerable prisoners physically safe. They had the bare minimum of furniture and no fixtures, fittings or furnishings with which the prisoner could harm himself. In many cases, prisoners were put into special anti-suicide clothing also. They once formed a key element of preventing suicides. Although their usage has been discouraged for some time (they had been banned for use with at risk prisoners since 2000), Ms Draper confirmed that other London prisons still had strip cells at the time. I saw for myself one of the former anti-suicide cells on visiting the now mothballed R wing. It represented a most depressing environment.

places but did not address the problem. Nevertheless, he was reluctant to take the crutch away. He did not want to make the 'outcome' worse (Pentonville had a relatively good record on self-inflicted deaths) solely to make the procedures better.

3.41 Mr Davies said the special cells were only for use by healthcare. He noted that they represented an attempt to turn Victorian cells into anti-ligature cells, but this was not satisfactory. There was a difficult balance to be struck between preventing suicides (for example, by removing prisoners' shoe-laces) and avoiding the negative impact of any measures. Mr Davies said he had thought about re-converting the AS cells, but was conscious of the uncertainty and fear this would create for healthcare staff. Nevertheless, he eventually got rid of them.

Observations

3.42 Officer Richards said monitoring of those at risk was better in the healthcare centre than it was on the wings because of the superior staff to prisoner ratio. All those considered at higher risk of self-harm were therefore placed in the healthcare centre.

3.43 Mr Attard explained that everybody in healthcare was on a routine 30 minute watch. There was then a range of different observation levels that could be used according to need. This included constant watch with the door open, gated cell observation, constant watch through the observation flap, 'engaged' 15 minute watches or simple 15 minute observations. There was a need for flexibility in approach, as what was needed sometimes changed by the minute.

3.44 Dr Ranaweera said everyone in the healthcare centre was on 15 minute supported watch. This would be increased to 'documented' when there was a risk of self-harm. A documented watch normally entailed more interaction because one person was designated to do it.

3.45 SO Hayward told the hearing that watches were often carried out through a locked door, but staff were able to speak to the prisoner. However, unless the prison was in patrol state, the nurse would normally sit just outside or just inside the cell, thereby facilitating interaction. Mr Hayward said he saw no point in the nurse simply watching the prisoner.

3.46 Officer Murray said that vulnerable prisoners could be put on constant watch in their cells, or alternatively moved to a ward where they could be observed constantly over 24 hours. He said staff engaged with the prisoners and that there were enough staff on duty to make this possible. He said prison officers (as opposed to nurses) tended to open the cell doors, the better to engage with prisoners.

3.47 PSN Japaul said they did not simply observe prisoners at stipulated intervals but engaged actively with them by talking to them, keeping them active, making cups of tea etc.

3.48 However, former PSN Emmanuel Ansong said that, while the key to dealing with those at risk of suicide was to communicate with them, discipline staff were reluctant to open the cells to facilitate this. It was difficult to talk in confidence to someone through a cell door. He said prisoners were locked up most of the day and there was little meaningful contact between them and staff. Officers only thought about discipline – especially when staff numbers were down. Mr Ansong said he got the impression that most discipline staff viewed self-harming prisoners as merely manipulative and attention seeking.

3.49 Mr Attard implicitly confirmed what Mr Ansong said about the lack of meaningful contact. He told us:

“I first got there, there was a big debate whether or not you should use a Registered General Nurse or a Registered Mental Nurse, the difference between the two is that the Registered Mental Nurse has had some psychiatric training and should really be doing proactive engaging of the person who they are watching, but that never ever happened, the reason being they don’t have keys, they never engaged with patients and it was just a waste of money.”

They therefore moved to using only Registered General Nurses.

Case reviews

3.50 Dr Ranaweera said there were twice weekly formal ward rounds which took place in Dr Yisa’s office. All the doctors, the pharmacist and the nurse in charge attended, and all relevant IMRs, nursing plans and treatment cards were present. Probation officers attended occasionally, but the probation officer allocated to healthcare was taken away. The ‘rounds’ lasted three or four hours and covered everyone, not just those on F2052SHs. Doctors presented their own patients to the ward round. This provided an opportunity to review what was happening with each of them. Dr Yisa would offer advice as necessary. (Dr Ranaweera added that doctors did not wait until the ward round to discuss cases with the nurses.) Later, and following the inception of the Mental Health Inreach Team, F2052SH case reviews were separated from ward rounds.

3.51 Healthcare officers also attended the ward rounds, but prisoners did not routinely do so – some of them would not have been suitable. However, the doctors might visit the patient after the rounds. Psychiatrists were not included in the ward rounds – this would have been a luxury. The chaplains sometimes attended. Dr Ranaweera advised that she could not recall having seen any recommendations relating to multi-disciplinary case conferences (but noted that this was some seven years previously).

3.52 Mr Attard explained to the hearing that he did not attend case reviews.⁴⁴ He confirmed, however, that the SMO, the responsible doctor, the

⁴⁴ It is worth noting that Mr Attard was, in effect, the unit manager.

pharmacist, and a nurse from the landing took part. Mr Attard said the lead consultant psychologist from Camlet Lodge (a medium secure mental health unit in North London) also attended.

3.53 Ms Japaul said she was not always involved in ward rounds. However, if one of the patients allocated to her was on an F2052SH she would have some input into the discussions and would receive immediate feedback about how he was to be managed.⁴⁵

3.54 Officer Richards said he did not take part in case conferences – they were mainly for nursing staff and doctors. He would have known who was to be discussed and, if he had any relevant concerns, would have told whichever nurse was attending. In that way, he could contribute if he had anything to offer. He said he did not recall getting much feedback unless he happened to be working in the area. Mr Richards said he could write on the prisoner's care plan if necessary. (This conflicts with Mr Leane's evidence, which was that discipline officers did not have access to the care plans.)

Samaritans and Listeners⁴⁶

3.55 At the public hearing, Mr Leane could not recall there being any notices on the wings about the Samaritans, but explained that there was a yellow Samaritans phone for prisoners' use. He said prisoners simply rang the cell buzzer when they wanted to use it. Similarly, when a prisoner wanted to see a Listener, he just asked a member of staff and one was found.

3.56 Mr Richards said there had been notices about the Samaritans around the prison since he first started there. There was no problem with Samaritans seeing prisoners, so long as it was safe to unlock them. Listener availability was never a problem either. They came either from other wings or from a couple of floors above the healthcare centre. He said a log of Listeners and their locations was kept on the wing. Asked if there was a shortage of Listeners during 2002, he said numbers fluctuated. It was a busy local prison and trained Listeners were continually leaving with others being recruited to replace them. He repeated, however, that a Listener could always be found.

Suicide prevention team

3.57 I draw here upon the minutes of the suicide prevention team meetings between October 2001 and March 2002:

October 2001

Key points from the meeting were:

- The quality of the F2052SH and frequency of case reviews was recorded as below standard and this was being reported to the relevant managers;

⁴⁵ This suggests that some form of key nurse system was in operation – if Ms Japaul has her timings right.

⁴⁶ Prisoners trained by the Samaritans to act in a similar capacity in prison.

- The annual training programme for suicide prevention was due to commence on 8 November and managers were asked to send staff who required refresher training;
- A memo had been sent to all unit managers reminding them that a key caseworker must be identified for every prisoner on an open F2052SH. This must be recorded on all case reviews;
- The outreach department from the Safer Custody Group had been asked to visit to provide help and support to staff of all grades.

November 2001

Key points from the meeting were:⁴⁷

- Key caseworkers were still not being assigned;
- Not all incidents of self-harm were being reported correctly (a notice to staff had been issued);
- The quality of the F2052SH had “definitely improved”;
- “Any wing manager who had not completed his or her daily checks and did not complete the case reviews on time and correctly would be subject to a please explain as this constitutes a failure of their core duties”;
- There was concern about vulnerable prisoners being located on unemployed landings. Managers were asked to take into consideration the need to maximise time out of cell for those at risk;
- The prison was not compliant with regard to:
 - ◆ Doctors not screening transfers in and change of status prisoners;
 - ◆ Timely case reviews;
 - ◆ Key caseworkers.

11 December 2001

Key points from the meeting were:⁴⁸

- The quality of F2052SHs “had definitely improved” and case reviews were being completed on time;
- “The next initiative to improve upon is for F2052SH document to accompany the prisoner everywhere.”
- Listeners books and passes had all been given out and the Listeners packs supplied to those Listeners who welcomed the new receptions;
- There was concern about Listeners refusing to come out and there was often more people requiring Listeners than those on call.⁴⁹

⁴⁷ A prisoner had killed himself in the period since the last meeting. Whilst this was mentioned during the meeting, there was no consideration of the circumstances of the death or lessons that might be learned (other than that he had self-harmed twice more than was recorded).

⁴⁸ A second prisoner had died at his own hand during the interim. Once again, and despite this being the second death in a very short period, there was no discussion of the circumstances.

⁴⁹ If Listeners were used a lot, they were given the next day off work (paid).

- Screening for transfers in and change of status prisoners was being addressed and would be reviewed in the New Year;
- Breakable shoelaces were to be introduced into healthcare and segregation.

8 January 2002

Key points from the meeting were:⁵⁰

- Key workers were now being appointed on “nearly all” case reviews;
- Chaplains were to be advised of their role in the F2052SH procedure;
- As well as the F2052SH accompanying the prisoner everywhere, improvement was sought in comments in the daily support record;
- Listener recruitment posters had been on display for a number of weeks;
- There was concern about a trend for self-harmers to be managed in healthcare. Healthcare staff were to provide support for managing such prisoners on normal location;
- Response to Thursday afternoon training had been “very low overall” and a new action plan targeting staff for early mornings or limited shutdowns was to be implemented;
- A referral form for prisoners identified as needing intervention from specified disciplines or agents had been introduced;
- A contribution form for completion by anyone unable to attend a case review had been introduced;
- A request was made for scissors or knives to be provided to Hotel 1 and 9 staff.

3.58 Mr Attard told the hearing that Ms Kay George, nurse in charge, and Dr Talat attended meetings of the suicide prevention team. He did not know why there was no mention of D at the January 2002 meeting. He said he would have expected him to have been mentioned at some stage.

3.59 None of the staff to whom we spoke could recall ever receiving feedback from the Suicide Prevention Management Group meetings.

HMCIP assessment of suicide prevention procedures

3.60 No inspection was conducted during 2001, but Pentonville was inspected by HM Chief Inspector either side of D’s attempted suicide. The earlier inspection took place between 11-18 October 1999 (that is, 26 months before D’s attempted suicide) and the later one between 2-4 September 2002 (that is, nine months afterwards).⁵¹ I think it is reasonable to assume that the state of play in December 2001 lay somewhere between the two.

⁵⁰ No mention was made of D’s attempted suicide.

⁵¹ The 1999 inspection was a full inspection. As a result, the report is comprehensive and detailed. The purpose of the 2002 inspection was to review progress on recommendations made following the earlier one. Such ‘short’ inspections do not cover every aspect of a prison. The disparity between the two reports in terms of detail and coverage means that, in the summary that follows, there is much greater reference to the earlier report. It is important

1999

3.61 HM Chief Inspector, Sir David Ramsbotham, noted that:⁵²

“There were good, efficient systems in place for monitoring and updating F2052SHs ... which included a daily check by the Governor. Visitors were encouraged to communicate their concerns about prisoners to prison staff and a poster had been put up in Visits with a contact number on it. That number rang through to the Centre, which was staffed 24 hours a day.”

3.62 Prisoners could contact the Samaritans via one of a number of dedicated telephones sited around the prison, but the Inspectorate was not persuaded of their accessibility outside association times. Prisoners could also contact the Samaritans from any other phone, using a freephone number. None of the phones had acoustic hoods.

3.63 The Listeners scheme was well established and their value was widely recognised. In addition, a Listener was employed in Reception as an orderly, and so was available to talk to newly arrived prisoners.

3.64 The Inspectorate was told that a member of the probation team interviewed all prisoners with an open F2052SH.

3.65 The Chief Inspector noted that seclusion of patients at risk of self-harm had recently ended and the consequences were being evaluated. He described this as a “welcome initiative” but commented that no additional resources had been made available.

3.66 Finally, the Chief Inspector was unimpressed with the ward as a resource for caring for those at risk. He said:

“The poverty of the regime for patients and the way in which the structure of the building prevented nurses from fulfilling their proper role, was particularly apparent with the eight-bedded ward. This was separate from other clinical areas and ‘nursing’ input was from a single nurse who sat behind a glass screen all day watching the patients but unable to talk to them or take any part in any therapeutic activity with them. Consequently most patients spent all their time lying inactive on their beds and the nurse’s skills were wasted.”

2002

3.67 Ms Anne Owers commented that the appointment of a full-time suicide prevention co-ordinator provided an opportunity for Pentonville not only to

to bear in mind that this may skew the balance by giving greater weight to how the prison was in 1999 than to the (evidently much improved) prison of 2002.

⁵² Sir David Ramsbotham was HM Chief Inspector of Prisons at the time of the first inspection. He was succeeded by Ms Anne Owers.

improve on existing processes, such as the F2052SH, but also to begin to develop some resources such as a first night centre. She also welcomed the existence of good quality cardiopulmonary resuscitation training, which she said was “essential training that provides swift and skilled response in saving life”. Ms Owers noted that “staff had responded appropriately to several emergency incidents in the past year”.

3.68 There was an active group of eight Listeners and a further ten prisoners were awaiting training. The Chief Inspector reported that they were well supported by the local Samaritans branch who attended a weekly support meeting. The Listeners were deployed in places where distressed prisoners could be identified. The Samaritans and a Listener attended suicide prevention meetings and there were proposals for the development of Listener suites.⁵³

3.69 The inspection team was pleased to discover that the senior psychologist worked with prisoners who self-harmed repeatedly. Nevertheless, the team identified:

“... room for considerable improvement in the F2052SH procedure. Three of the at risk forms we looked at showed that no initial reviews, which should be conducted within 72 hours, had taken place. Instead, the first recorded reviews had taken place several weeks after the F2052SH had been opened. Many of the entries in the support record were superficial and, as we find in many prisons, showed little evidence that staff were talking to prisoner to check on their well-being.

“... The support plans that we looked at in Pentonville lacked substance.

“The minutes of a recent suicide prevention meeting noted some of the difficulties in ensuring staff training in suicide prevention. Staffing problems had meant that this training was being targeted at new staff and officers arriving from the training school. Chairing F2052SH reviews is a key area of suicide prevention training and one that is often neglected.

When a F2052SH was closed, which can be a time of increased risk, support for the prisoner was often withdrawn. A system should be introduced by which some contact is maintained in the following weeks to ensure that individual prisoners are maintaining the apparent progress that led to the closure of the form.”⁵⁴

⁵³ Specially converted cells. It is perhaps worth noting that the suicide prevention team had first considered proposals for the suites at the end of 2001.

⁵⁴ Mr Davies implied at the hearing that the report was not a fair reflection of the position at Pentonville. He said they had been carrying significant staff vacancies and were able to deliver only half the regime. There was disquiet amongst prisoners, culminating in a riot. The inspection team turned up the following day. This context accounted for some of the criticisms in the report – including the lack of recorded observations of prisoners at risk. He went on to say that Pentonville had rated a double good for the suicide prevention audit during 2001/2002 with a mark of 82 per cent.

Board of Visitors (BoV)

3.70 The 2001 BoV annual report said that reception had worked at full capacity during the year and staff efforts to provide a good service were hampered by “the increasing number of late arrivals brought by Securicor from courts”. The Board also referred to a lack of ‘nurse hours’ in reception.

3.71 The Board’s report noted that, although the overall figures for training were up, “there was little training for suicide prevention”. They said, “It still happens too often that training staff put on a course and nobody attends.” The report continued:

“The Board has been told by the Governor that it is not possible to deliver all the training that is mandatory, but the lack of training in suicide prevention – and this does not seem likely to be redressed in the near future – cannot be acceptable.”

It went on:

“The Suicide Prevention Team has again met regularly throughout the year, but attendance has been variable particularly from medical staff and wing governors. This is a cause for concern.

“There have been changes of management personnel within the group which has meant that implementing new procedures has not been as swift and effective as it should be. It is, however, good to report that suicide prevention training was finally being offered to a large number of officers from the end of the year under review.

“The ‘interesting and innovative procedures’ referred to in last year’s report were not implemented as planned, and mandatory new procedures are not always adhered to e.g. reviewing of prisoners after seventy two hours on F2052SH forms.

“The increase in the number of suicides – to three this year – is sad to report and is deeply upsetting not only for families, friends and other prisoners, but also for the many staff trying to offer a good and sensitive service.”

3.72 The Board said the help offered by Listeners had been invaluable and recruitment, selection and training were improving. However, “The fact that there are still delays in the use of Listeners because of failure on the part of management to ensure that they have passes is not acceptable.” The Board commended the Samaritans for “the consistently high standard of their work within the prison”.

3.73 Referring to criticism about insufficient refresher training in suicide prevention, Mr Davies explained to the inquiry that each officer was scheduled for 39 hours per week. Once ‘non-effective’ hours were taken out, this

reduced to 32.8. The time available during non-effective hours was insufficient for the amount of mandatory training required. In addition, the influx of new staff meant that there was a huge training requirement. In any case, the mandatory requirement for suicide prevention training was that this should take place within 12 months of taking up post. There was no mandatory requirement for refresher training.

3.74 Mr Davies said the F2052SHs were seen by all those visiting the wings. The duty governor in particular had a responsibility to check them. They would identify any shortcomings and feedback directly to the officer concerned. This was more effective than bespoke training. In addition, it was extremely rare for the morning meetings not to refer to an incident of self-harm during the previous 24 hours. Mr Davies presided over these meetings wherever possible and always raised the issue. Everyone was aware – but especially the governors who were inspecting the forms. Mr Davies said he also carried out routine checks himself. By the end of 2001, entries had improved. Staff realised how important it was to complete the documents fully – if only out of self-interest. Mr Davies said he had sacked an officer for making a facetious remark on an F2052SH and no-one (including the Prison Officers Association) had demurred. Checks would not include following up on care plans, however. That was a matter for the named person or department. He said he was looking only for good quality entries.

3.75 Mr Davies said that, despite everything that was done, he was not confident that suicide prevention was under control. He said the threat of suicide was “numbing, terrifying”. He never went to bed confident that there would be no fatalities.

Consideration

3.76 By the end of 2001, Pentonville had in place a comprehensive suicide prevention policy that fully embraced the general principles underpinning the F2052SH ethos and procedures. Significantly, it set out the particular responsibilities of various staff in relation to those at risk. They had someone dedicated to the area and a suicide prevention team that met regularly.

3.77 However, both HM Chief Inspector and the BoV were critical of the standard of completion of F2052SHs and of gaps in staff training. The suicide prevention team was clearly aware of both issues, but the fact that the same items recurred repeatedly at meetings suggests there was a failure properly to get a grip. The Prison Service has argued that the attention afforded to these issues by the suicide prevention team demonstrates that the prison was working to address them. The Service has also suggested that both issues applied across the prison estate and were not peculiar to Pentonville. I accept this. But it is probably also significant that staff to whom we spoke said they rarely (if ever) received any feedback from suicide prevention team meetings. Taking all this together, I am led to question the overall effectiveness of the suicide prevention team.

3.78 I am also concerned that, where specific responsibilities under F2052SH were ascribed, they related only to residential areas. It is clear that, although F2052SH was also intended for use in healthcare and the policy included a section on healthcare responsibilities, it did not give a corresponding breakdown of roles and responsibilities. Hence, specific tasks (such as ensuring support plans were implemented) were not allocated to specific people or grades in the healthcare centre. No doubt this resulted from an entirely proper reflection of the different regime, patient oversight and line management operating in the healthcare centre. The Prison Service has argued that a team approach obtained and that it was for the Senior Medical Officer, senior nurse and healthcare managers to ascribe responsibilities to individuals as they saw fit on a daily basis. They have also suggested that the policy document should not be so overly prescriptive as to deny flexibility and autonomy of staff working on the ground. Nevertheless, I consider the failure to set out detailed responsibilities to have been a significant flaw.

3.79 Generally speaking, however, I judge that Pentonville was reasonably on top of suicide prevention procedures. Despite the criticisms of Ms Owers and the BoV and concerns noted at suicide prevention team meetings, the prison scored well on its internal audit. I am also in no doubt as to Mr Davies' personal commitment to preventing suicides and to ensuring this remained at the forefront of staff's minds.

Current suicide prevention policy

3.80 The introduction of F2052SH between 1992 and 1994 was designed to shift the focus of suicide prevention away from merely clinical intervention. Many of those who died at their own hands had been diagnosed as not clinically depressed and so not identified as at risk. F2052SH recognised that self-harm and suicide were not purely medical phenomena. Poor coping skills, situational depression and significant events were major contributory factors. The range of responses therefore needed to match the range of factors that placed the prisoner at risk. F2052SH made suicide prevention everyone's concern (a phrase first used in a major report by Sir David Ramsbotham himself) and enabled anybody working in a prison to open an F2052SH form, thereby triggering special care and management of the prisoner. The intervention too was intended to be multi-disciplinary and to involve the prisoner him or herself in the decision making process. There was to be a care plan aimed at addressing the prisoner's particular needs and this was to be reviewed by a multi-disciplinary team on a regular basis.

3.81 The Prison Service submitted to the investigation a statement by Mr Michael Gibbs, Deputy Head of the Safer Custody Group, setting out recent developments in suicide prevention. Mr Gibbs advised that a review of F2052SH was carried out in 2002, resulting in the development of ACCT (Assessment, Care in Custody and Teamwork). ACCT was intended to improve aspects of the identification and care of those at risk of self-harm and suicide, including more effective screening and assessment, a care planning system that allowed for different levels of intervention tailored to the particular

prisoner's needs, better inter-disciplinary communication, the therapeutic engagement of at-risk prisoners and further staff training. Mr Gibbs said:

"The underlying imperative of ACCT was the development of a holistic and proactive system to help at risk prisoners and to build on the existing strengths of the F2052SH model ... it had to be a meaningful process to assist prison staff to manage and assess vulnerable prisoners during periods of crisis. The emphasis is on engagement and interaction with the prisoner, and ultimately to identify (and where possible resolve) the underlying problems leading to self-harming behaviour, or at the least to provide useful coping mechanisms. The key thinking behind ACCT has been ensuring that there is not a 'one size fits all' system ...

"ACCT aims to improve the quality of care for prisoners at risk of self-harm by introducing flexible care planning that is prisoner-centred, supported by improved staff training in assessing and understanding at risk prisoners ... It focuses on an individual assessment, uses accountable case managers and assessors, encourages flexible care, and sets up clear systems to deal with post-closure and post-release care. It is aimed at 'people not processes'.

"Under ACCT, a trained assessor interviews the prisoner within 24 hours of risk being identified. The assessor contributes to the first case review (which should happen within that same first 24 hour period). Named ACCT case managers are responsible for ensuring that case reviews happen and the care plan is followed. Unit managers must check the ACCT plan on a daily basis and senior managers should check it on a weekly basis. The ACCT plan is closed only when a case review determines that it is safe to do so. Reviews should be attended by the case manager and others relevant to the prisoner, for example, the assessor, unit manager, healthcare staff, relevant member of the chaplaincy team, and – ideally – the prisoner him or herself."

3.82 Mr Gibbs advised that there had been a reduction in self-inflicted deaths amongst prisoners in each of the previous four years. (Sadly, that trend did not continue during 2007.)⁵⁵

3.83 Mr Nigel Myers, Safer Custody Manager at Pentonville, presented the inquiry with an overview of the introduction of ACCT into Pentonville. He said it was launched between October and November 2005 following a "comprehensive training package" for all permanent and agency staff. Regular refresher training had been provided as well as some training sessions for specifically targeted groups such as healthcare staff, governor grades and those working with segregated prisoners. Initial problems revolving around lack of staff confidence had been overcome, and Mr Myers judged that all staff at the prison were now comfortable with the system.

⁵⁵ The number of self inflicted deaths in prison in 2007 was 92 compared with 67 in 2006.

3.84 Mr Myers advised that he reviewed all open ACCT plans on a weekly basis to ensure that staff were making meaningful entries and reported his findings to the Suicide Prevention Committee.

3.85 Mr Myers noted that, during the 12 months preceding the launch of ACCT at Pentonville, there had been four self-inflicted deaths at Pentonville. Since its launch, there had been just one – on 18 June 2007.

3.86 Mr Jonathan Warren, the current healthcare manager at Pentonville, said in a statement to the investigation that there were four levels of supervision for at-risk prisoners, ranging from once daily/twice nightly to one-to-one constant observation. An agency or healthcare nurse could be used for the purpose. The level of observation could be determined by a member of the healthcare team or by an ACCT assessor. It could be altered according to the changing needs of the prisoner.

3.87 I strongly welcome ACCT. It enhances previous practice and procedure and, as Mr Gibbs says, builds on the strengths of F2052SH. As policies go, ACCT is well designed, comprehensive, ambitious but achievable. However, as with all policies, its success depends on the commitment of senior managers to making it work, proper training, and the diligence of individual members of staff. Without each of these elements, it is ambitious but not achievable.

PART IV - APPLICATION OF THE SUICIDE PREVENTION POLICY IN RELATION TO D

Reception

4.1 The correct procedure was followed by Securicor staff after D self-harmed at court in that an F2052SH was opened. This duly arrived at Pentonville with D and staff identified that he was at risk. Sensibly, they allocated D to a ward (which would facilitate his interaction with others as well as close observation), and referred him urgently to the doctor. She saw him that evening. D remained on an open F2052SH for the duration of his time at the prison.

4.2 It is clear from the Inmate Information System that D had been considered to be at risk of self-harm during previous periods in custody. However, Ms Draper explained to the hearing that medical staff in reception would not have had access to that information. In fact, no information relating to previous periods of custody was available to reception officers – unless the prisoner himself divulged details.

4.3 Dr Ranaweera said that it was open to staff to obtain previous prison records (it is worth stressing that this was not routine Prison Service practice or procedure), but this of course depended on their being aware both that the prisoner had been in custody before and that anything of note had occurred. Ms Draper's manuscript notes from D's IMR make clear that staff were aware that he had been in custody before. There is no mention, however, of his having self-harmed or having been at risk of self-harm during those times.

4.4 On behalf of D, Ms Stern said in her closing statement:

“... there is no evidence that the system [Dr Ranaweera] described in her evidence of requesting information from other agencies took place. This is critical in the case of D. D arrived at HMP Pentonville on an open F2052SH. She should therefore have contacted the Whitechapel Hospital where he was treated for his injuries on 30 November 2001. Had she done so, she would have been immediately alerted to his previous history of self-harm. The records ... would have disclosed the incident of 14 June 2001, which incident records the most detailed psychiatric evaluation of D to be found at any point. The interview notes run to nine pages. They refer to medication, depression, a past psychiatric history of stabbing himself, eating glass, hanging himself, and jumping in front of cars. With this sort of information, it is reasonably likely that additional psychiatric input (and most probably treatment, including medication) would have been sought or trialled, and D's reports of voices telling him to harm himself would have been taken more seriously.”

4.5 Clearly, information from his previous records would have been useful in determining how best to manage D at Pentonville. I have found no evidence to suggest that Pentonville obtained his previous IMR or previous

F2052SHs. It may or may not be significant that Ms Draper does not refer to earlier records in her report or manuscript notes. Given the volume of paperwork that has gone missing, I cannot of course say with certainty that D's old records were not obtained, but on balance I think it unlikely that they were.

4.6 Pentonville's policy at the time did not require staff to obtain earlier prison records. Generally, in a busy local prison such a requirement may not be practicable, and I do not imagine many local prisons (either at the time or now) would routinely do so. However, both Dr Yisa and Dr Ranaweera have given evidence that they would request them if they considered they would be of particular assistance. Given D's behaviour and presentation, together with the level of concern that led staff to refer him urgently to a psychiatrist, I find it surprising that they did not do so in this instance. I would have thought a first step would have been to obtain such information as there was, and to discuss with colleagues elsewhere what they had tried and what appeared to work (if anything) with D.

Detoxification

4.7 Sir David Ramsbotham reported in his 1999 inspection report that all new prisoners coming into Pentonville were screened for drug use by healthcare staff and, where appropriate, referral was made to the specialist detoxification (detox) nurses for assessment and treatment. However, there were no systems for referral to other services within the prison for those who did not require urgent medical intervention.

4.8 Prisoners requiring detoxification were housed on C2 and C3 landings and were generally assessed by a member of the specialist team within 24 hours of reception. This normally worked well, but on occasion the system had broken down when none of the detoxification nurses was on duty and prisoners had to wait several days before receiving medication.

4.9 Assessment, prescribing and dispensing of methadone (the main drug used for detoxification) was carried out professionally and efficiently, despite there being possibly 40 – 50 prisoners on detox at any one time.

4.10 Aside from medical intervention, little else was offered in terms of reassurance or support. Prisoners were out of cell for a maximum of two hours per day and received no structured counselling or group-work. Sir David noted:

“The detox nurses had no time to undertake any proactive work with the prisoners and the landing officers were not trained in working with either drug users or specific issues related to detoxification. We spoke to prisoners who recounted their time on C2 and C3 as being lonely and frightening with an overall sense of abandonment.”

Sir David added that 21 out of 90 incidents of self-harm had occurred on the two landings.

4.11 In 2002, Sir David's successor, Ms Anne Owers, noted that:

"The CARATs manager estimated that 80% of new admissions suffered from a serious form of drug addiction, with a particularly high proportion of poly-drug misusers. Given the extent and complexity of the difficulties these prisoners experienced, we were concerned that the available post-assessment follow-up facilities remained inadequate."

4.12 Dr Ranaweera explained that in 2001 detox was carried out in the healthcare centre. She said prisoners would be given either Librium or Diazepam detox (which was the same as was used now), at a dosage appropriate to the level of dependency, for either seven or ten days. Dr Ranaweera said they had a good local policy on drug withdrawal at that time. She explained that, although intended only as a treatment for alcohol addiction, either drug would have a sedative effect.

4.13 Prisoners who are withdrawing from drugs can be at greater risk of self-harm. It is clear from records obtained from the Royal Free Hospital that D was on Diazepam until 9 December 2001, and Ms Draper's manuscript note taken from the IMR shows that he was already on the medication when the F2169 form was completed. Since this is a reception screening form, it seems that he was on Diazepam when he arrived at Pentonville and that the prison then continued the prescription. This suggests that, clinically at least, his drug addiction was properly addressed. What is much less clear is the level of support he received whilst he was withdrawing.⁵⁶ The reports from both Chief Inspectors leave room for doubt in this respect, as do the varying accounts given by staff about time out of cell (albeit that it is clear from the evidence that efforts were being made to provide a more stimulating regime – I look at this more closely in Parts VII and VIII). I am struck also by Mr Richards' recollection that D's cell was devoid of any means of occupying him. This is relevant both to his withdrawal and his risk of self-harm. Treatment of both would have benefited from some in-cell occupation, regardless of the amount of time out of cell available. Having seen the cells in which D was located, and in light of what we learned about the regime that obtained at the time,⁵⁷ I can only assume that his period of detoxification must have been a miserable one. (The likelihood that he found it so is suggested by his behaviour during his first ten days or so in prison.)

Assessing risk

4.14 It would be easy to say that D was at high risk of self-harm throughout his time at Pentonville merely by reference to the number of established indicators of risk. He was a young man experiencing his first taste of an adult prison, on remand, charged with a violent offence. He had a history of self-harm, of contact with mental health professionals and of drug misuse. He

⁵⁶ Prison Service Order 3550 Clinical Services for Substance Misusers provided guidance on regimes for prisoners undergoing detoxification. (The guidance was not mandatory.)

⁵⁷ I consider the regime in Part VII.

also drank heavily. Finally, he was experiencing relationship problems with his girlfriend. All these elements marked him out as someone with a raised risk of self-harm.

4.15 Questioned at the public hearing about the recognised indications of possible risk, Officer Richards pointed out that the indicator 'young man' was not helpful as the vast majority of prisoners at Pentonville fell into this category. He added that staff dealt with a very wide variety of prisoners. Mr Richards said he was fully aware of the indicators, but they applied to everyone who came into prison. The indicators did not help narrow the field.

4.16 Mr Richards agreed that previous incidents of self-harm could be an indicator, but said it was a question of degree and intent. An attempted suicide was different from someone who self-harmed by way of stress relief. An act of self-harm would have heightened the risk but Mr Richards said his actions would have been the same as for those saying they would self-harm – that is, he would open an F2052SH. Seriousness of risk depended on the individual.

4.17 Mr Davies said the throughput at Pentonville was huge and that the chances of missing a “slip-catch” were quite high. In her evidence, Ms Ruth Kringle, former Deputy Governor, said that there was great difficulty in identifying vulnerable prisoners. The high churn factor (80 – 100 new receptions every day) did not help staff to make quality assessments. The high number of open F2052SHs (typically 30 F2052SHs at any one time) could be explained in part by staff erring on the side of caution because they did not have time to make a proper assessment.

Was D (consistently) an at risk prisoner?

4.18 The questions I must answer are: what specific risk did D present and did this risk change during the time he was at Pentonville?

4.19 Professor Rogers⁵⁸ noted in his statement to the inquiry that it was well known in the Prison Service that previous self-harming behaviour was a significant risk factor for a later suicide attempt. In light of this and the knowledge of D's history of self-harm, he was “surprised” that the risk of D attempting suicide “was not considered more seriously”. Furthermore, he counted at least 16 separate instances of self-harm whilst D was at Pentonville.

4.20 In assessing the risk presented by D, Professor Rogers focussed on his history of self-harm (and continuing self-harm whilst in prison) and on the 'command hallucinations' he reported. Professor Rogers told the hearing there was a correlation between the seriousness of the self-harm and the likelihood of an attempted suicide. The more violent the self-harm (amongst men) the more likely it was that an attempted suicide would follow. He said

⁵⁸ D's representatives engaged Professor Paul Rogers PhD, MSc (Econ), RN, Cert ENB 650 Beh Psychotherapy, Dip Beh Psychotherapy, Professor of Forensic Nursing to provide, *pro bono*, an assessment of D's care at Pentonville.

more than one in ten who self-harmed (in the community) went on to commit suicide. Self-harm was a very strong warning sign.

4.21 Professor Rogers discussed the significance of D's complaint about hearing voices. He noted that clinicians at the time of D's suicide attempts were uncertain as to the relationship between 'command hallucinations' and self-harming behaviour. However, the general consensus was that the presence of command hallucinations was worrying considering the risk an individual posed.⁵⁹ He told the hearing that this was a view taken by psychiatrists at the time. He added that the research was fairly mainstream for psychiatrists but not necessarily so for doctors. However, some knowledge about a link between self-harm and command hallucinations had filtered into text books.

4.22 Professor Rogers told the hearing that studies in the 1990s into command hallucinations suggested that people tried to appease voices telling them to kill themselves by some lesser act than what was commanded – so self-harmed rather than attempted suicide. It was a form of coping strategy. Professor Rogers said it was significant that D had previously acted as a result of command hallucinations.

4.23 He considered it was not reasonable for the case conference on 13 December 2001 to conclude that D had settled. He suggested that, if D seemed more settled, staff should instead have asked themselves why this was. He said the clinical team still did not understand what they were dealing with. They should have asked why D had been quiet for a few days. It might have been that the medication was having an effect (Professor Rogers said emergency sedation took up to three days to reach its peak concentration). D had been given Chlorpromazine on 10 December (Professor Rogers was not sure whether this was a repeat prescription or a one-off) and this might have explained why he appeared settled. He said staff should have found out whether the voices had gone away and whether the problem with D's girlfriend was resolved. They needed to ascertain whether the underlying risk had changed. He said the apparent improvement might have been symptomatic of the calm that sometimes preceded a suicide attempt.

4.24 Professor Rogers said that, if nothing else, the hanging attempt on 13 December "predicted uncertainty" and demonstrated D's impulsivity. It should have led staff to question their earlier judgement and ask what they had missed in order to avoid the same mistake again.

4.25 The apparent trigger on 13 December was D's request to see a doctor. Professor Rogers said this suggested he was at the end of his tether. The refusal might have left him frustrated and reinforced his sense of hopelessness and that nothing was going to get any better. If he was saying "Please help me," it suggested that all his coping strategies had failed. Professor Rogers said there may have been some relevance in the sexual

⁵⁹ In 2002, Professor Rogers published the first paper that found a relationship between command hallucinations telling a person to self-harm and actual self-harm attempts.

nature of D's comments, but this was impossible to determine without knowing what he said.

4.26 Professor Rogers also argued that doctors should have attached significance to D's previous references to his daughter in the context of self-harm. He added it seemed likely that the attempts were pre-planned.

4.27 In his evidence, Dr Cumming⁶⁰ took a different view in nearly every respect. He said in his statement:

“One should be cautious in interpreting self injurious behaviour in the same way at all times. Looking at D there are many events which fall within this umbrella but undoubtedly they fall across a scale. One could be reasonably confident with some that there was no likelihood of actual death ... Whilst trying not to devalue the distress that D felt, I would argue that only the earlier hanging had any real chance of actual death.”

Dr Cumming also noted that theorists remained divided over the exact relationship between self-harm and suicide. Whilst nearly half of those who committed suicide had a history of self-harm, only a small proportion of those who repeatedly harmed themselves went on to commit suicide.

4.28 Dr Cumming commented that D had many of the risk factors for self-harm in custody. But risk was not a static phenomenon and the bulk of D's self-harm or threats to self-harm were clustered around his first eight days: “Thereafter there are peaks but the risk is much lower than the first eight days.” Dr Cumming suggested that the initial high incidence of self-harm might have been related to D's period of withdrawal.

4.29 At the hearing, Dr Cumming said Professor Rogers' figure of one in ten self-harmers going on to kill themselves did not translate to prison. He did not know what the relevance was of the nature of the self-harm, but said what Professor Rogers had said about seriousness and the likelihood of a suicide attempt sounded logical and reasonable. This was perhaps why D had been retained in the healthcare centre after the attempt on 13 December. However, Dr Cumming noted that risk was not static and that the overall trend in D's self-harm was down except for the ‘spike’ on 13 December. He suggested there might have been a possible relationship to the detox.⁶¹

4.30 Dr Cumming considered that Professor Rogers' suggestion of a ‘calm before the storm’ was generalising. It would follow that everyone who had self-harmed should remain on constant watch. It was not a practical way to approach the question. It was more logical simply to say that the risk was diminishing. He suggested that D had a background risk, which was never

⁶⁰ Upon receipt of Professor Rogers' review, the Prison Service instructed Dr Ian Cumming MB BS MRCPsych to consider Professor Rogers's findings and provide a second opinion on D's clinical care.

⁶¹ Dr Cumming accepted, however, that an alternative interpretation of the pattern of D's self-harm was that he had consistently self-harmed twice a week over a two week period.

eliminated. It fluctuated, with the biggest risk being at the beginning. However, Dr Cumming confirmed that this did not mean D became low risk.

4.31 Dr Cumming said the nature of the events was more pertinent than the number. The hanging on 13 December was the most serious and followed a bout of disruptive behaviour. Dr Cumming suggested it came “very much ‘out of the blue’”. This indicated that D did not feel his needs were being met. Such a reaction to not getting his own way was consistent with a borderline personality disorder. (Dr Cumming commented that he did not consider it was appropriate for prisoners to have medication to sleep during the day.) Although such impulsivity and unpredictability was an indicator of future self-harm, it was necessarily difficult to manage. Nevertheless, Dr Cumming suggested that the decision not to put D back on one-to-one observations “seems to be correct” as there was more limited self-harm over the next 13 days.

4.32 He considered it was possible that D wanted the noose and razor to be found on 27 December. He suggested there was a need to keep an open mind.

4.33 Dr Cumming described D’s situation as “persistent background risk on top of which were acute periods of risk”. Given all that we know about D, it is hard to argue with this conclusion. However, the question is how great the risk was during the non-acute periods.

4.34 Suicide risk or risk of self-harm is not static, and it is likely that the risk D presented fluctuated constantly during the month he was at Pentonville. He was a young man who presented many of the established indicators of raised risk, added to which was his uncertain mental health. It seems to me that, until staff at Pentonville properly understood D’s problems and needs, it would have been appropriate to treat him as at high risk. Notwithstanding the fact that suicide risk rises and falls (and can disappear), I agree with Professor Rogers that it was somewhat precipitate to conclude on 13 December that D had settled and could be discharged from the healthcare centre.

4.35 I also agree that, whatever his presentation on 13 December, the signs were that any bad news relating to his girlfriend or daughter would be likely to push D over the edge. Of course, it is possible that the discharge plan that was apparently drawn up for him at the case conference on 13 December took account of this. However, if that was the case, it rather begs the question why staff did not have any guidance on how to manage D prior to and following his phonecall on 27 December.

Response to risk

Location

4.36 It is a standard part of suicide prevention strategy (and a specific element of Pentonville’s) wherever possible to place vulnerable prisoners in shared accommodation. This ensures that the vulnerable prisoner is not

isolated and has someone with whom to interact and discuss their feelings. It also means that they are effectively under constant supervision.

4.37 There were no shared cells in the healthcare centre. There was a ward, but Dr Ranaweera estimated that about 20 per cent of patients would have been on open F2052SHs. This proportion fluctuated but, given that the ward held just eight people, it meant that a significant number of prisoners considered to be at risk of harm had of necessity to be located in single cells.

4.38 Inevitably, this affected the ability of the healthcare centre to locate D in such a way as to reduce risk. Staff were further constrained in what they could do by D's disruptive behaviour. (Dr Ranaweera suggested that it was D's disruptive behaviour that led to his several changes of accommodation - that is, between a normal healthcare cell, ward and anti-suicide cell.) This meant that it was not always appropriate to locate him on the ward. Hence, although he was quite properly placed in ward 3 on arrival at Pentonville, D was moved the following day to an anti-suicide cell after he threw things around. He was given just one further chance on the ward.

4.39 I accept that D probably had to be moved because of his disruptive behaviour, but there were several periods - especially during the second half of December - when his behaviour does not appear to have given much cause for concern. Certainly, he was not smashing up his cell and threatening staff on a daily basis. Given the evident vulnerability of D and his limited coping strategies, I wonder whether the ward might have been used in a more proactive (and not simply reactive) way. (In suggesting this, however, I am not unmindful of the needs of other prisoners and staff's duty to protect them.) Instead, staff appear to have given up on the ward as a means of addressing D's vulnerability after just three days at the prison (at which time D was detoxing and at his most volatile).

4.40 I am equally concerned by the use made of the anti-suicide cells. Mr Leane said the special cells had beds bolted to the floor, and no chairs or tables. The only 'natural' light came through thick glass blocks set in the wall. Mr Attard described the cells as 'miserable' and Ms Kringle explained that the anti-suicide cells were not purpose built but were ordinary cells which had been adapted. She said the quality was poor (but then the quality of all the accommodation was poor) and they were not fit for purpose. Prison Service Nurse (PSN) Smith told us that the anti-suicide cells were "dark, no sanitation, horrible". He explained that the window glass was opaque and below ground level and that, as a result, very little light got into the cells. He told us the cells were used for both prisoners with mental health problems and for self-harmers.

4.41 Despite their formal designation, the consensus amongst staff appears to have been that the anti-suicide cells were used to contain violent or disruptive prisoners at least as much as they were to prevent self-harm. PSN Ansong said the anti-suicide cells were used for those who misbehaved. People were put in them for cutting themselves, "as it caused inconvenience to staff". He said they remained in the cells until they complied. PSN

Boateng said the semi-furnished cell was used for violent prisoners, although it was sometimes used for those at risk of self-harm. Mr Leane clarified that the cells were not used as a punishment but for containing violent prisoners. Mr Hayward told the hearing the AS cells were used for violent prisoners in lieu of moving them to segregation. Healthcare staff considered that they were better placed to deal with such prisoners, calming them down, interacting with them and then returning them as quickly as possible to the landing. (However, he added that the AS cells were perceived by prisoners to amount to segregation.)

4.42 Mr Davies was challenged with the suggestion that D was put in an AS cell after he smashed up his cell – including ripping out the plumbing – and that if it had happened on the wing, the prisoner would have been removed to a special cell in the segregation unit (for which authorisation was required). Mr Davies said that, if he had thought use of the AS cells was being abused, he would have done something. The whole point of special procedures was to protect everyone.

4.43 It is not clear how long D remained in the anti-suicide cell on the first occasion, but it is possible from my reading of the records that we have that it was from 1-3 December. This is a long time to be in such conditions. On the second occasion, D was in the AS cells for a matter of hours. On the third occasion, he seems to have remained there from 13-15 December, though he attended court on 14 December. Again, and notwithstanding the respite whilst at court, this was a very long time. It seems unlikely that this would have benefited D's state of mind, albeit that it might have kept him physically safe.

4.44 In light of staff comments about the use to which the anti-suicide cells were put and D's undoubtedly disruptive, sometimes violent behaviour, I have considered why he was placed in the cell on those three occasions. I conclude that he was first moved to the AS cell (on 1 December) as a result of his disruptive behaviour. There is no suggestion that risk of self-harm played a part. No reason is given in the surviving documentation for the move on 4 December, but Mr Richards had inferred that this too was the result of D's disruptive behaviour. Given that he went on to smash the toilet in the AS cell, this might be correct. However, Ms Draper, who had access to contemporaneous documentation, said in her report that the move to "a safe cell" resulted from him "once again self-harming" (she did not give any details). Ms Draper goes on to say that D was described as "hysterical, agitated and unco-operative, and he claimed that he could hear voices that were telling him that they were going for his daughter". On the other hand, D smashed up his cell on 13 December but was not moved to the anti-suicide cell until he tried to hang himself. It seems likely that this represented an attempt to address risk whilst also taking account of his violent behaviour – that is, it was not considered appropriate to locate him on the ward. It seems that on this third occasion too use of the anti-suicide cell was an attempt to address both sides of the risk presented by D.

4.45 I conclude, therefore that putting D in the AS cells was not solely part of the strategy for preventing him from harming himself but was partly a means of containing a violent prisoner. Of course, it was impossible for staff to separate out the disruptive, violent prisoner from the prisoner who was at risk of self-harm. In the circumstances, it is hard to argue that he should have been on a ward or in shared accommodation, but I have great unease about the use of semi-furnished cells.

4.46 Use of so-called strip cells was banned for use with prisoners at risk of suicide in March 2000 (Prison Service Instruction 27/2000 refers). This was in the face of evidence that, whilst they might physically prevent a prisoner from harming himself, they were degrading, inhumane and lacking in anything to occupy the mind and tended therefore to exacerbate the prisoner's vulnerable condition. 'Caring for the Suicidal in Custody' said:

"The use of unfurnished or protective accommodation is inappropriate for suicidal prisoners. It takes away the prisoner's dignity and control, and is often felt to be punitive. The trust of prisoners in staff will be undermined. They will be less likely to admit to distress in the future, and may even see suicide as a way of reasserting control of their destiny."

4.47 In light of this guidance, I cannot see that it was appropriate to place D in an anti-suicide cell whilst he was recognised as being at risk of suicide. The Prison Service has argued that the PSI allowed "exceptionally" for the use of such cells when an at-risk prisoner was violent or refractory. In fact, the PSI said they could be used in "very rare circumstances". I do not consider three times in the space of less than a month to have met this criterion. In addition, and given the timing of D's move to an anti-suicide cell on 13 December in particular, I am not persuaded that containment as opposed to physically preventing D from self-harming was the reason for the move.

Observation

4.48 The level of observations was varied throughout D's time at Pentonville. Bearing in mind evidence presented to the investigation that all patients were on a 15 minute watch,⁶² the level of observation was as follows:

30 November - 1 December – in ward 3
1 December - 15 minutes documented
3 December - in ward 3
4 December - anti-suicide cell
 - then to a single cell, 15 minutes documented
 - then one-to-one
6 December - once an hour
10 December - 15 minute documented
11 December - 15 minute supported

⁶² Thirty minutes in some evidence. Apparently, the policy was not written down anywhere.

13 December - to anti-suicide cell, one-to-one
14 December - anti-suicide cell, 15 minute documented
15 December - single cell
18 December - 15 minute supported⁶³

4.49 D was placed on constant observations just twice. The first was after a period when he had self-harmed three times in the space of 24 hours, and the second was after his attempt to hang himself on 13 December. In other words, D was put on constant watch when the risk was at its most acute. As Dr Cumming has suggested, this was entirely appropriate. Whilst the most certain way of keeping D safe would have been to have him watched constantly all the time, it is likely that he would have found the practice intrusive and de-humanising. It would also of course have represented a considerable investment of resources. Whilst it is entirely proper that constant watch should be used when it is necessary, it simply would not be practicable or helpful to have all those at risk of self-harm watched 24 hours a day.

4.50 As Dr Cumming has also suggested, the adjustments to the levels of watch suggest that staff were monitoring D closely and trying to manage the level of risk presented at a given time.

4.51 However, Dr Cumming noted that, following cessation of the one-to-one observations, “there was a gradual and careful reduction of his watch – this demonstrates that they wanted to reduce his watch but did not want to abandon it. It shows that they were being cautious and measured in their approach.” Whilst this is true on the second occasion, the evidence available suggests it was not on the first. On that occasion, there was an apparent reduction in watch from one-to-one (on 4 December) to once hourly on 6 December. This is a big step and difficult to understand. However, given that the investigation has been told all patients were routinely observed at either 15 or 30 minute intervals, I am not sure what significance to attach to it. Indeed, it is entirely possible (given the missing documentation) that there was a step between these two levels.

4.52 I am concerned that watches of whatever level may have been no more than a mechanical means of ensuring the prisoner stayed safe. Whilst such mechanical suicide prevention represents a vast improvement on using an anti-suicide cell, I am disappointed that such observations did not apparently entail a high level of active support. I say this partly because of the pressures that self-evidently formed part of the daily routine in a busy, under-resourced healthcare centre, and partly because of the physical constraints presented by the cell door with its narrow flap. We heard some evidence that staff sat with the door open in order to engage with the prisoner, but others have suggested little support was given. Dr Ranaweera said the amount of engagement between staff and prisoners depended on the level of staffing that obtained at the time. The prisoner’s own demeanour was also a

⁶³ D had been placed on documented watch on 14 December until he was seen by a doctor. Ms Draper did not mention whether the watch remained in place when he was moved to a single cell. It is not clear therefore whether the supported watch on 18 December was an increase or decrease in the level of observation.

consideration, especially if he was threatening people. When pressed at the hearing on whether a ratio of one member of staff to observe six patients was sufficient, Dr Ranaweera said it would be better if the person doing the checks had more time to spend with the prisoner. Certainly, it is difficult to imagine that there was sufficient opportunity for any meaningful engagement.

4.53 Nurse Chikuku confirmed that, in carrying out observations, she was acting in her capacity as Registered Mental Nurse and that the observations themselves were more than simply a form filling exercise. She said it was important to interact with the patient. However, cells made this difficult. In addition, the opportunities for actually talking to the patient were limited by the numbers that had to be observed and the need to make entries. In order to carry out observations effectively, she would want to know a brief history of the person to be observed. However, whilst she was aware of care plans on the wards, she would not have seen any if she was carrying out observations. Similarly, she had access to the IMR on the wards, but not when she was downstairs (carrying out observations). In any case, there would have been no time to refer to the IMR. She could not recall if she had had any previous dealings with D and said that all she knew about him would have come from the (brief) shift handover. She said her general approach was to look in through the open flap, say hello and ask how the prisoner was doing, how they were feeling etc. She thought that about half responded.

4.54 She told Ms Draper that some prisoners found it difficult to engage with agency staff with whom they had had no opportunity to build up a rapport. She said:

“He [D] was really quiet. I should say low in mood but most of the time if you asked him if there is something bothering him, do you want to talk about anything because we are agency, they don’t really see us more often, they wouldn’t open up but he was really low in mood because in the morning he asked to shave ...”

4.55 In contrast, at the hearing Nurse Chikuku suggested some prisoners found it easier to talk to people they did not know. No doubt both things could be true. Nurse Chikuku has stressed that she conducted her observations with care and professionalism, and that she tried to look at the patient in front of her and assess how they were feeling and behaving. She tried to form a relationship with the patient by interacting with them “as best as one could in the prison environment”. But given that all Nurse Chikuku knew about D was what she was told in a brief handover on 27 December, it is difficult to see how she could have interacted with him at anything more than a superficial level. More specifically, it is unlikely that she would have known about the single subject that concerned him most (his daughter). I note that prison staff said that individual agency staff worked regularly in the prison (and so might have been better acquainted with D), but I see no reason to suppose that Ms Chikuku’s position and experience in this respect differed from any of the agency nurses charged with carrying out observations on him. I fully acknowledge that many suicide attempts occur apparently out of the blue and that awareness of potential triggers can only achieve so much. Nevertheless,

if certain events are known to be likely to prompt a prisoner to self-harm, it stands to reason that all staff charged with his care should be aware of them.

4.56 I was also struck by Mr Attard's comments about mental health trained nurses not being necessary for constant observations because of the lack of real interaction as agency nurses did not carry keys. It seems to me that, by switching to generalist nurses, Pentonville missed the point. Instead of identifying a drain on the budget, they might have considered what the purpose of constant watches was supposed to be and how they could ensure that the money spent on RMNs could be put to effective use during constant observations.

4.57 'Caring for the Suicidal In Custody' says:

"Supervision of the suicidal should be active, involving supportive contact rather than mere observation. This avoids stigmatisation and builds a positive relationship in which both prisoner and staff will feel more secure."

I am not persuaded that this was the case with D.

Case reviews

4.58 Carole Draper noted in her report that there were several case conferences, but neither D himself nor any non-clinical staff were involved. She commented that "these criticisms" had been made frequently in death in custody reports for Pentonville.

4.59 It was clear from all those to whom we spoke that prisoners did not routinely attend case reviews in the healthcare centre (although some staff told us that they might go to see the prisoner or invite him in afterwards to discuss their conclusions). Similarly, whilst one officer told us that case reviews had at some time been multi-disciplinary, the consensus was that by December 2001 they were not.

4.60 Mr Davies acknowledged that reviews were not always multi-disciplinary. He said the frequency with which they had to be held, together with the range of people required, had to be set alongside the very high numbers of F2052SHs. Some functions had very small staff numbers and could have spent all their time in case reviews. He said the policy was more aspirational than achievable. In addition, the suicide prevention committee quickly decided that, although establishing key workers was in the right spirit, it was not entirely practical. He said he embraced the multi-disciplinary principle – there was value in the various contributions – but questioned whether it was better to postpone a case review when everyone was not available or go ahead with those who were. Mr Davies said his Area Manager challenged him on this point, but he had consistently argued that multi-disciplinary case reviews simply were not practicable.

4.61 'Caring for the Suicidal in Custody' proposes:

“Each case review should involve the prisoner unless it is felt to be in their best interests to be excluded ... All staff working supportively with the prisoner should be present. It is not appropriate for staff who are not involved to attend unless the prisoner gives consent.”

In addition, the document says that, “Case reviews will normally be unit-based but it is important for unit managers to make the fullest possible use of other departments and agencies.” Changes or additions to the support plan should be made with the prisoner’s agreement. Nevertheless, it is uncertain whether the requirement for multi-disciplinary case reviews attended by the prisoner applied to healthcare, as staff guidance notes on the completion of the F2052SH said, “Case reviews will normally apply to prisoners who are being managed on normal location or are about to be discharged from the healthcare centre.”

4.62 I imagine this was at least partly in recognition that healthcare centres have their own established systems for reviewing patient care. However, I am surprised that the guidance did not promote a multi-disciplinary approach in healthcare too. The whole thrust of the policy was that suicide was not an exclusively clinical problem, but had many causes and hence many potential interventions. If Pentonville was not strictly in breach of national guidelines, it would surely have been best practice for case reviews to have been multi-disciplinary. I note the logistical difficulties of achieving this. However, even if it was not possible to achieve the physical presence of all parties, their input should have been sought (perhaps on paper), and there should have been a means of feeding back to them the conclusions reached.

4.63 Ms Draper, who had access to D’s records, commented, “it should be noted that D was not seen by a doctor from 18-27 December, or if he was, there was not an entry made in his IMR.” Dr Yisa was at pains to stress at the hearing that Dr Ranaweera was amongst the most meticulous of doctors with regard to record keeping. She was away from the prison from 25 December, but this does not account for the lack of IMR entries in the period 18-25 December. I can only conclude that D was not seen by a doctor, or at least not by Dr Ranaweera, during this time. I am also puzzled that there do not appear to have been any case reviews after 18 December, despite the fact that case reviews apparently took place in the context of the twice weekly ward rounds. There was no national or local requirement to hold case reviews at specified periods, but medical officers were required under Pentonville’s suicide prevention policy to review at risk in-patients daily. It is worrying that D seems to have disappeared from sight for a while.

Communication

4.64 Of the various documents in use on the healthcare centre (observation books, IMR, care plans, F2052SH, prisoner’s record), only an extract from the wing observation book could be found in relation to D. It is therefore difficult to assess the extent to which information about him was communicated in each of these documents. However, it is clear from Carole Draper’s report

that some information was recorded in the IMR or F2052SH that was not recorded in the wing observation book.⁶⁴

The adequacy of support planning

4.65 This investigation has not had access to D's F2052SH and therefore any support plans created for him. From Ms Draper's account, however, it seems the support plan(s) was to observe/support D at specified intervals, refer him to, variously, the Listeners, the Samaritans, probation and the chaplaincy and, to refer D urgently to a psychiatrist and psychologist. (I consider the final element – urgent referral to a psychiatrist and psychologist – in more detail in Part IX.)

4.66 Little of this appears to have been implemented. The level of observation was varied (although I have considered above the degree of support that was involved), but the internal referrals do not appear to have taken place. (Ms Draper said the normal process was for a message to be passed to whoever was organising those to whom the referral was to be made to say that contact would be useful.) Ms Draper commented in her report that she had not been shown any documentary evidence that the chaplaincy or probation had any contact with D as per the care plan.⁶⁵ She added that, given D's particular concerns, she was "extremely surprised" that probation was not called at an early stage. She observed that she had not seen or heard of a probation officer being regularly involved in the healthcare centre, despite a particular officer having been given healthcare as an area of specific responsibility.

4.67 At the hearing, Ms Draper said she would have talked to the relevant personnel (education, chaplaincy, probation) if no reports were forthcoming. There was no evidence, however, that referrals were followed up despite the number of references to them in the case conferences. She confirmed that this was something she had specifically looked into.

4.68 Dr Yisa said the process for referrals to Listeners was for the lead nurse to make a note of the referral and make the necessary arrangements. He suggested there were issues around confidentiality so it would not necessarily be documented. He said that it was for the nurses also to contact probation – but that there were too few probation officers at that time. However, the fact that someone should be seen should have been recorded in the nurses' notes.

4.69 Dr Ranaweera said at the hearing that the F2052SH support plan was drawn up by doctors but fell to nurses to implement it. The plan was kept in the nurses' station and aimed at helping the individual in relation to the

⁶⁴ Ms Draper explained that issues that had an impact on others and the operation of the landing should be recorded in both the F2052SH and the observation books. However, issues that were significant only in relation to the particular individuals only needed to be recorded in the F2052SH.

⁶⁵ I asked for the chaplaincy log for the relevant period, but it could not be found. I was told that there were no probation records either.

problems causing him to be at risk. (They were different from 'care plans', which were more health oriented.) It was the nurses therefore who would ensure that referrals to a chaplain, Samaritan or Listener actually took place. Of course, if the prisoner did not want to speak to someone, he could not be forced to do so. Dr Ranaweera was not sure if prisoners had their own 'key nurse' and was not sure how the work was divided up. It was not the doctors' responsibility.

4.70 Mr Hayward told the hearing that healthcare staff were responsible for implementing the support plans. A healthcare worker would attend the case review and he or she was responsible for ensuring that any referrals actually happened. Mr Hayward said there were problems getting wing, chaplain and probation staff to the case reviews. The healthcare worker would take the F2052SH along to the case review, note down what was decided and then put it into motion.

4.71 He said the chaplain was a regular visitor to healthcare, and he was sure D's referral would have been brought up with him or a note placed in his bag by the healthcare worker at the meeting. He explained that the probation office was only four doors away from where the case reviews were carried out, so the responsible healthcare worker would either have gone to speak to them about D or have put a note under the door. He said the Samaritans attended regularly, but he could not recall how referrals to them were effected.

4.72 Mr Richards suggested to the hearing that, where the care plan said refer to whoever, it meant that the prisoner should be advised that so and so was available – not that a member of staff should ensure that the prisoner was seen by the person mentioned. Mr Richards added that it was the responsibility of whoever wrote the care plan to ensure it was actioned. He told the public hearing there was no reason why D could not have been seen by the chaplain, Listeners or Samaritans. It would have been recorded in the F2052SH as well as any visits he had.

4.73 Ms Draper said she had no sense of there being a lack of Listeners at D's time and no difficulties over access. She said staff were very clear on arrangements in this respect. She noted that an officer might suggest a Listener to the prisoner, but the prisoner did not have to agree to see one.

4.74 Mr Attard explained to the hearing that prisoners accessed probation via an application form submitted to a nurse or officer. He could see no reason why a referral to a Listener would not have happened. Samaritans could be accessed by phone or via Listeners. Mr Attard was not aware of the process for referring someone to the Samaritans.

4.75 Dr Cumming suggested it would be wrong to assume that no meaningful interaction with D took place. He noted that there was "no particular record" of D using the Samaritans or Listeners, but commented that in his experience the lack of records for these groups was not uncommon. Their use was a component of the F2052SH strategy and "it might be wrong to assume that he was not seen".

4.76 I am afraid I am not persuaded by Dr Cumming's argument (albeit that record keeping in prisons is often patchy). If probation or the chaplaincy visited D, there should have been details in his F2052SH. It is unlikely that either the Samaritans or a Listener would have made an entry (though in principle I see no reason why they should not), but I would have expected there to have been a record that contact had been made – it was no secret, after all, that D was a suicide risk.

4.77 I do not believe it was a question of poor record keeping in this instance. In light of Ms Draper's confirmation that she specifically looked into this point, I think it is almost certain that there was no contact. This is very regrettable. In effect, it meant that the support plan amounted to staff observing D at intervals.

4.78 I have not been able to identify the cause of this failure. Staff appear to have been clear that it was for nursing staff to implement support plans, and the plans themselves were readily accessible. Mr Hayward suggested that a single nurse who attended the case reviews was responsible for actioning the plan. Assuming the nurse's name appeared on the plan, this seems to me to be a relatively sound mechanism to ensure implementation. This would suggest that the failing was personal rather than systemic. However, I do not know who the named person was. Ms Draper does not refer to such a person and I would have expected her to have done so. I infer no-one was allocated the role.

4.79 Several people have made the point that referring D was one thing and his agreement to speaking to whomever was quite another. I also found Mr Richards' explanation of the meaning of 'referral' in this instance quite compelling. However, I would have expected there to have been a record of D's refusal or of the fact he had been told about the bodies who might be able to help him. It would have been a way for staff to demonstrate that they had done what they could. It would also have provided useful information to the next case review. There would have been little point in continuing to instruct that D should be referred if he was not interested, and another strategy could have been identified.

4.80 Ms Draper was critical that F2052SHs were removed for sometimes considerable periods for the case conferences. She suggested that this might have been overcome if a member of staff actually working with the prisoner was invited to attend, bringing with them both the prisoner and the F2052SH. Ms Draper noted that this would have also provided, "an immediate handover to other staff as to the results of the case conference and any alterations to the care plan". She also thought that follow up to referrals might have been more likely if the case conferences had been multi-disciplinary. Professor Rogers argued there should have been a key nurse who was responsible for D's care 24 hours a day. I consider there is merit in all these points.⁶⁶

⁶⁶ The Prison Service has suggested that "such a model would not work constructively within the prison setting". They have said that prisons operate on team work and the collective responsibility of the staff to care for their prisoners. However, I see no reason why such a

4.81 However, success would still depend on the individual doing their job properly. The only way to ensure that happens is if managers carry out regular checks. However, Mr Davies confirmed at the hearing that, although the duty governor routinely checked F2052SHs, the checks did not include following up on support plans. Pentonville's suicide prevention policy allocated this responsibility on the wings to the senior officer. It is silent on the question of who is responsible for in-patients at-risk.

4.82 I note that Mr Hayward, one of the senior officers in healthcare at the time, referred at the hearing to his having a responsibility to check that the reviews had taken place but not to checking whether support plans had been actioned. He said the policy as it related to residential senior officers did not apply to him as a healthcare senior officer, and that ensuring support plans were implemented was the job of nurses or healthcare staff who were "associated" with the patient. This might indeed have been the case, but I question the selective translation of senior officer responsibilities from residential to healthcare. Nurses and healthcare officers might well have been tasked with following through on support plans but, given their importance, a manager should have been tasked with overseeing the process. Certainly, it would have been helpful if Pentonville's suicide prevention policy had been clearer on this point. The policy (properly) reflected a difference in practice and procedure in the two areas, but failed to ensure there was a full marrying up of suicide prevention procedures with healthcare procedures and protocols.

4.83 I am concerned that, in the event, the support plan was not implemented. But I am also concerned by the paucity of the plan itself. It is not simply that it lacked imagination (though it certainly did), but that it did not address D's specific needs (with the exception of his mental health issues, which I consider in Part IX). Ms Stern said of this:

"There was no proper system in place for care planning. There is no evidence before the Inquiry that there was any adequate care planning in place for D. No attempt appears to have been made to identify risk factors, minimise these, or to manage D in order to anticipate or adequately prevent incidents of self-harm. Rather, the approach was reactive, dealing with D after outbursts of aggression or self-harm."

4.84 Professor Rogers suggested that D's anxiety surrounding his daughter being taken into care could have been predicted, purely on the basis of what he had told staff. He was critical of the absence of a more proactive approach in this respect, including a clear management plan to support D. He considered that D should have had a social worker appointed to his case to determine the family situation and report to the clinical team, and that clinical staff should then have prepared D for his daughter being taken into care if this looked likely. He said an effective support plan would have given a clear

model would not be appropriate. On the contrary, I consider it would enhance the provision of care.

indication of what needed to be done and the triggers for self-harm. It should have explained what the current position was and how it should be managed, and also have described potential situations and how they should be managed. (I consider the ramifications of a lack of such a plan on the events of 27 December in Part V.)

4.85 Like Dr Cumming, I am sceptical about how realistic it might have been to expect social worker involvement. I also note the Prison Service's point that prisons do not have unlimited options when dealing with prisons on a day to day basis. But certainly probation could have been asked to address this very specific issue (rather than a general 'refer to probation'). D's concerns about his daughter were absolutely key (I have noted earlier that they remain at the forefront of his mind today). If a support plan did nothing else it should have got to grips with this issue.

4.86 For example, it might have provided D with greater access to a phone. HM Chief Inspector of Prisons' 1999 report noted that there were many phones installed around the establishment, including the workshops. However, "The reality for many prisoners was that access to these phones was so infrequent and unpredictable that the phones became a source of angst and frustration rather than a facility for maintaining meaningful contact with their families and friends." In 2002, the Chief Inspector reported that access to telephones was still inadequate.

4.87 Mr Leane advised that, generally speaking, prisoners had good access to phones, with one cardphone being provided on the 1s and possibly another on the 2s. In fact, access depended on the amount of time out of cell, demand from other prisoners and the prisoner's own resources. It seems likely that D's own access to a phone would have been very limited. Time out of cell appears to have been at best erratic, and we know that (by 27 December at least) D did not have a phonecard. This was significant both in terms of the external support on which he might have drawn and allowing him to keep track of – and even influence – events in relation to his daughter. (More regular phone contact might have made the phonecall on 27 December of much lesser significance.)

4.88 I infer that court appearances were also a trigger point for D. On 3 December, he threatened to kill himself "by Friday next, before he has his court appearance". He ripped up a bed sheet on 6 December (the day before the court appearance) and self-harmed at court the following day. D's first hanging attempt, on 13 December 2001, occurred the day before a court appearance. He threw things around his cell the day before his next appearance on 20 December and was noted to be apprehensive during the night. I presume he was due in court on 27 December, but do not know whether the court would in fact have sat during the holiday period. It should not have been rocket science to factor this element into a support plan. However, no additional precautions appear to have been taken in periods leading to D's court appearances.

4.89 Mr Richards said support plans tended to be the same – that is, interact more, refer to the chaplain/Samaritans etc. He said they tended to cover the same areas as a matter of course because there were limited options in a prison.

4.90 It was always a danger that support plans would become formulaic, but that was not the intention. When the national policy was drawn up, the intention was that staff would identify the specific causes of a prisoner's vulnerability. This might relate to his charges, his likely sentence, housing issues on the outside, relationship problems, drug issues, loneliness or bullying. In devising support plans, staff were intended to identify the particular issue(s) for the prisoner and to construct a plan accordingly. It is extremely regrettable that this did not happen in D's case.

Assessment of D's care

4.91 Having had access to D's records and having spoken to staff much nearer the time in question, Ms Draper concluded that "on the whole" D appeared to have been well-managed and staff appeared to know him quite well. She noted that he was a very disturbed young man in an adult prison for the first time. His behaviour gave "great concern" to staff working in healthcare and, "a great deal of time was spent with him, either individually or as a result of case conferences".

4.92 Dr Ranaweera thought staff would have spent a lot of time with D given his particular profile, and that what documentation that remained tended to illustrate this. In particular, she noted that D had been retained in the healthcare centre despite the very high demand on beds. She said this was the only place where he could be afforded appropriate levels of support and supervision.

4.93 On the other hand, Professor Rogers concluded that, "the management of D was inadequate during his admission and prior to his suicide attempt". He commented on the lack of detailed information about the care planning meetings that reportedly took place. He added that, as far as he could determine, none took place after 13 December despite the suicide attempt on that day.

4.94 Professor Rogers also noted that, at the time staff were holding a case conference on 13 December where they considered D to "have settled well and not to be either clinically depressed or suicidal," he was in fact asking for medication to help him sleep and then went on to throw his furniture round his cell while shouting abuse.

4.95 In concluding this section of his report, Professor Rogers said:

"The acute demands of the service at any given time can outweigh the ability of the clinical staff's or prison officers' ability to ensure best practice at all times and even follow policies. Nonetheless, it is my opinion that the manner in which D's care and treatment was managed

fell well below acceptable standards even considering the acute demands of working in a prison healthcare centre. Furthermore, I believe that the manner in which his individual case was managed raises a number of serious concerns as to the way in which prisoners were cared for in Pentonville Prison in 2001.”

4.96 Dr Cumming argued that, in managing or containing the risk, a number of options were employed, which “demonstrated flexibility in approach”. He noted that D was accommodated in a variety of locations at different times (ward, anti-suicide cell, cell with 15 minute observations) and concluded that each move was proper in light of the particular circumstances obtaining. (He commented that, “we must not forget that in December 2001 there were many other patients apart from D and their safety also had to be ensured”.) He noted that one-to-one observations were introduced appropriately but that, whilst they usually managed the risk, they did not necessarily address the risk very well. Dr Cumming said that, following cessation of the one-to-one observations, “there was a gradual and careful reduction of his watch – this demonstrates that they wanted to reduce his watch but did not want to abandon it. It shows that they were being cautious and measured in their approach.”

4.97 Dr Cumming commented that to his knowledge the involvement of social workers in prisons was non-existent in 2001. He said he would “argue that the position is most likely being seen in the wrong direction” and that the responsibility lay with Social Services to communicate with D.

4.98 Dr Cumming inferred that the comment that D “would not elaborate” on his shouted remark that he was going to die that night (25 December 2001) was evidence that someone had tried to engage with him. (However, Ms Stern suggested that there was “a real prospect that a trained professional might have been able to elicit more information.”)

4.99 Concluding this section of his report, Dr Cumming said:

“I believe that overall, the approach to managing the risk that D presented is reasonably logical and demonstrates a specific approach to D – this could only occur after consideration of the issues and risks. I did not feel therefore that this was casual – D was clearly central in the thoughts and assessments of the various members of the team on a number of occasions; also this must be seen in context to other prisoners. Although this review and inquiry is about D, he was not the only prisoner; there were a large number and turnover of other prisoners some of whom would present similar challenges. In terms of the risk surrounding the final event, his reaction is clearly related to an external factor rather than something inherent in the prison. It is worth noting that staff probably had the perception that D’s risk was being managed and was coloured by threats and his behaviour. In my experience responsive management is quite often a feature of prisoners who manifest a combination of disruptive behaviour and self-harm.”

4.100 Dr Cumming suggested that the proposal that either could be eliminated was “clearly chasing rainbows”. He reported that, at the time of D’s suicide attempt, an average of 1,000 prisoners nationwide were sufficiently at risk to warrant F2052SH management. Such statistics were important in assessing success or failure.

4.101 Mr Eadie endorsed this conclusion in his closing submission. He suggested that the documents available and the recollections of staff indicated that “the care and management of D generally was appropriate to his needs”. To support this, he reiterated that:

- D was on an open F2052SH in healthcare throughout his time;
- Staff were aware of the risk and D was dealt with accordingly; and
- His location and watch were varied according to the particular circumstances.

4.101 However, in her closing submission, Ms Stern said staff appeared to have been inadequately trained to deal with the likes of D. She said:

“There was a lack of detailed psychiatric training which is clearly a serious failing given the evidence as to the prevalence of mental health issues at HMP Pentonville. The reality is that the healthcare officers were simply not properly trained in the nuances of suicide prevention, and thus were not capable of understanding the complexity of the presentation of those at risk of self-harm.”

4.102 I agree that, whilst staff were able to offer details of the mechanics of suicide prevention (identification, form filling, observation and location), few offered any insight into the need effectively to engage with the prisoner and deal with his particular needs.

4.103 I am critical that more use was not made of the ward, that D was placed in an anti-suicide cell on several occasions, that observations may have involved little if any engagement with him, and that referrals to the chaplain etc were not followed up. Put like this, it would seem that the care afforded to D was lacking. However, there are few deaths in custody where it is not possible to say that more could have been done. It is easy to be wise after the event, and this report must reflect the fact that staff were looking after many vulnerable and challenging prisoners in a poorly set-up healthcare wing of a busy local prison.

4.104 Given that D’s core record and IMR were not available to the investigation, it is perhaps remarkable that we know so much about D. Part of this is due to Ms Draper’s report, but it is clear from the contemporaneous records we have that D was on the radar in healthcare. Considering the numbers held there, the turnover of the population and the fact that D was described as being not unlike many other prisoners, the observation book mentions him a number of times. Intended only as a general source of information for staff, it provides quite a bit of information about the way D was

cared for. Dr Ranaweera said it was clear that D was given a lot of attention, and I think that is probably correct (albeit in the particular context that obtained at the time). I think it is also probably safe to assume that the missing documents, which were specific to D, would contain significantly more information about his care. (Certainly, Ms Draper was able to provide considerable detail without setting out verbatim what the documents said). I believe it is fair to conclude that what we know of D's care is only part of the story. In the context of a busy and ill-designed healthcare facility, I consider the day to day care afforded to D was within the bounds of what was reasonable.

4.105 The Prison Service has substantially revised its suicide prevention procedures since 2001. Whilst I welcome the changes introduced by ACCT, I have considered whether D's care would have been substantially different if it had been in operation at the time. This is not in order to judge actions taken then by the standards prevailing today, but to ascertain the extent to which there remain lessons to be learned.

4.106 I consider that ACCT is a significant improvement on what existed before, but as I have said the effectiveness of any policy is in the implementation. If underlying principles are ignored, the policy will fail. Under the old system, D should have been involved in discussions about how best to manage him, and support plans should have addressed his particular needs. He should also have been supported by the active engagement of staff, and a key worker should have been appointed to take particular responsibility for his care. All this is, which pre-figures what was to come with ACCT, was in the policy. Little of it was achieved.

4.107 It is noticeable that, in talking about the F2052SH procedures, staff were strong on identification of risk and the mechanics of the process. This apparently formed the basis of their training. When asked how those at risk were managed, few mentioned support, concentrating instead on the more tangible location and level of watch provided. None spoke of active intervention to address the prisoner's needs.

4.108 My concern, of course, is that notwithstanding the significant enhancements to policy offered by ACCT, it offers no guarantees with regard to implementation. If D was not included in case reviews despite the policy at the time saying that he should be, what difference would ACCT have made? If referrals were not followed up under the old procedure (which required a key worker to be appointed to co-ordinate the prisoner's care), what are the guarantees that they would be under ACCT?

4.109 The current policy is intended to provide a bespoke approach for each prisoner. This too was the ethos underpinning F2052SH. The challenge for the Prison Service is to find ways of ensuring that ACCT stays fresh and is not corrupted by familiarity and usage so that responses become routine and formulaic. Ironically, the greatest danger in this respect lies where the numbers of prisoners requiring ACCT are highest – that is, where the risk is greatest.

I recommend that the Prison Service conducts a formal review of ACCT to ensure it remains fresh, properly implemented, and attuned to individual circumstances.

PART V – 27 DECEMBER 2001

Morning

5.1 Nurse Chikuku was the nurse charged with carrying out the 15 minute documented observations on D.⁶⁷ She said at the hearing that she did not receive any training from the prison when she started work there. Her agency had explained her role in relation to watching prisoners on open F2052SHs and recording her observations, but she was told nothing about the more general working of the form or why or by whom it could be opened. She said she did not read the whole F2052SH form – she only saw the observation sheets.

5.2 She could not recall whether she had had any previous dealings with D and could not remember what she had been told about him. She did not remember whether she was told he was a poor coper, violent/abusive, demanding, problematic, had previously self-harmed, had concerns about his daughter, or about the razor and noose that had been found that morning. (She said that she would not have given D a razor, as she had, if she had known about the finds in his cell that morning.) Nor could she recall whether she had been told about his attempt to hang himself on 13 December.

5.3 Nurse Chikuku said she would not have had time to read the patient notes for those she was observing. She said the only information she would have had about D was what was said at the handover. This was extremely limited and generalised and simply updated staff on how the particular prisoner was. No background information would be forthcoming. Her knowledge of them was therefore quite limited. She based her judgement about the level of risk on the level of observations that had been directed. For this reason, she inferred that D was a medium risk.

Cell find

5.4 Officer Richards recorded in the observation book that he had found a noose and razors during the locks, bolts and bars check that morning. He did not record where he found them, although at the public hearing he said he would normally do so. He surmised that he must have found them in empty cells. He did not recall finding a razor or noose in D's cell, but could not remember where he did find them. He said he would have made an entry in the F2052SH and wondered if it might have been "a somewhat manic day". He acknowledged that it was a poor note that did not help anyone.

5.5 Ms Draper's report said quite specifically, however, that a noose and broken razor blade were found in D's cell. She added the detail that D said that the former was for cutting matches and the noose was intended as a joke. It is not clear where Ms Draper got her information from – she did not mention it during her interviews with staff. However, given the detail she

⁶⁷ By the time Ms Draper conducted her investigation, the record was missing. However, there does not appear to be any question but that Ms Chikuku carried out the observations as she was required to do.

provided I am persuaded that she did not simply assume that the noose and razor blade were found in D's cell but found the information in another document. This suggests that Officer Richards acted appropriately on the find in terms of reporting it (in that he must have recorded it in the F2052SH) – and Ms Draper added in her report that he also told a senior officer.

5.6 Healthcare Senior Officer Hayward agreed that the record of cell search finds on the morning of 27 December should have provided more detail. He could not recall whether he was aware that a noose and razor had been found in D's cell, but said he would have expected to have been told. However, razors were found on a daily basis. He said this might have been the result of a failure properly to count them out and back in, but equally they might have been found in empty cells after many months. He said nooses were not found frequently, but it was not overly unusual. In nine out of ten cases the prisoner himself would draw staff's attention to a noose. Mr Hayward acknowledged that the frequency of these incidents carried with them a danger of complacency. The judgement call made on the day was critical. Potentially, all prisoners could be on constant observation. It was therefore necessary to make quite fine judgements and to treat each case on its merits. Some who actually attempted suicide had given no previous sign. It was necessary to assume that everyone was serious.

5.7 Ms Chikuku said she could not recall whether she was told about the cell find.

Cell flap

5.8 Nurse Chikuku said that D kept covering his cell flap with newspaper during the morning of 27 December. She explained to him that she needed to be able to see him and told him not to do it again. At the hearing, she said she reported the matter to officers, not because she was concerned about the significance of D's behaviour but because she thought it more likely he would take notice of them. She told Ms Draper that, in the event, D did stop covering the cell flap.

The phonecall

5.9 Mr Leane surmised at the public hearing that his knowledge of why D wanted the phonecall came from the call itself rather than what D told him at the time. However, he agreed that the fact the phonecall was given at public expense (which was not common), and despite D having smashed up his cell, suggested that he was persuaded at the time that it was important.

5.10 Mr Leane said he was not familiar with Standing Order (SO) 13⁶⁸ and had not seen it before. He was not aware of the requirement for consulting a doctor when a prisoner was to be given bad news.

⁶⁸ Standing Orders are permanent prison regulations. Standing Order 13 relates to healthcare.

5.11 At the public hearing, Mr Hayward explained that 27 December was his first day back after a period of leave. On his return to the prison, he would have informed himself about any F2052SHs and familiarised himself with the observation book. This would only have included recent entries, but he would therefore have known a certain amount about D.⁶⁹ Mr Hayward said he did not routinely look in the IMRs, but the care plans provided a running commentary. He would not have been aware that D had been listed but not seen by a psychiatrist, and could not recall whether he knew about D's attempted hanging on 13 December.

5.12 Mr Hayward said he did not know D well and could not recall any contact with him. He had not attended any case reviews for D.

5.13 Mr Hayward said he thought Mr Leane approached him about a phonecall for D just after lunch. He could not recall what the issue was, but that D had smashed up his cell and he and Mr Leane had discussed the matter.

5.14 Mr Hayward had noted "NFA" (no further action) in the observation book in relation to the damage to the cell because he thought there were serious issues to be dealt with outside the disciplinary process. (However, he added that, if he had considered there were clinical issues arising, he would also have made a note in the F2052SH and the IMR.) He therefore decided to give D the phonecall and, since he had no phonecard, this was to be from the office. He said he wanted to calm the situation bearing in mind that D had smashed his cell and been abusive and violent. Mr Hayward agreed that it was not common to give calls from the office, and could not explain why he had granted one in this case given that cell smash ups were not that unusual. He said D was clearly frustrated about something, but he could not recall if he knew at the time or only afterwards about D's problems with his girlfriend. When told that Mr Leane said he (Mr Leane) did not know until afterwards, Mr Hayward commented that Mr Leane's recollection would be better than his.⁷⁰

5.15 Nurse Chikuku said she did not recall whether she was told about D smashing up his cell or whether she was consulted about the phonecall.

After the phonecall

5.16 Mr Leane told the public hearing that he would not have done anything differently with D after the phonecall if he had known about the noose and razor being found that morning or about D's earlier threat to kill himself. He had passed on his concerns to someone who could do something. (Mr Leane told the public hearing he could not authorise one-to-one watches. Instead, he would refer to a higher grade.) He could not remember speaking to the nurse carrying out the 15 minute checks but was "sure" he would have done. During the preliminary interview, Mr Leane said he thought Mr Hayward would

⁶⁹ It is worth noting that, by this time, it was two weeks since D had self-harmed.

⁷⁰ This is at odds with the evidence given to Ms Draper. Mr Hayward at least implied that Mr Leane had explained about D's girlfriend when asking for the phonecall.

have told other staff on the wing and said he (Mr Leane) would also have told his colleagues if he had come across them, but could not remember doing so.

5.17 We asked Mr Leane whether there was any alternative to returning D to his cell at that time. Mr Leane thought there might have been, but it was quite busy and, in any case, there was not a lot for D to do on the wing. He said he could have asked if he had wanted to come out.

5.18 Mr Hayward said Mr Leane took D back to his cell and then immediately returned to the 'bubble' (the office) to report the phonecall. When pressed, Mr Hayward said one reason for returning D to his cell would have been in order to contain him. He suggested that the possibility of D smashing up again was a proper consideration. (Mr Hayward commented at preliminary interview that he did not think there was an alternative to locking D back up and that he was under close scrutiny anyway.) He said he did not even consider the possibility of not putting D back in his cell, but thought Mr Leane had done the right thing.

5.19 Mr Hayward said he would have followed Mr Leane to D's cell if he had felt from D's demeanour there was any cause for concern. Asked what "staff to be vigilant" was intended to mean, given that D was already on 15 minute watch, Mr Hayward said it meant that staff should take it upon themselves outside of the formal watch to keep an eye on D.⁷¹

5.20 Mr Hayward told the hearing he was familiar with Standing Order 13 and agreed that the medical officer should, in certain circumstances, be consulted about those who had received (as opposed to those who were going to receive) bad news.⁷²

5.21 Mr Hayward said that, if the alarm had not sounded immediately, he would have gone to see D himself and perhaps raised the level of supervision. He would not simply have left him. Mr Hayward added that, given the time span that obtained, he would not have done anything differently – even if he had known about the noose and razor being found that morning and the earlier attempted hanging. It would have been open to him to consider placing D on constant watch, but there simply was no time to do so.

5.22 Mr Richards did not recall having seen Mr Hayward's observation book entry at the time, but said that, if he saw it now, he would go and have a chat with the prisoner. He added that not everyone coming onto the landing (for

⁷¹ Mr Leane said he thought "Staff need to be vigilant" meant that they should keep an eye on him, but did not suggest that anything more than a 15 minute watch was required. He thought it referred to being vigilant when D was out of his cell.

⁷² However, Dr Yisa said in his statement that, "... although Standing Order 13 states that a doctor should be present if bad news is to be conveyed to the prisoner, I must say that this is a very antiquated document. It had been heavily amended and was only maintained in force until such time as a new nationwide policy could be formulated. It should be remembered that HMP Pentonville was ahead of its time in terms of the management of self-harmers and that staff were well accustomed to dealing with disturbed prisoners." I do not consider the point unreasonable. The Standing Order preceded the de-medicalisation of care for those at risk.

visits or whatever) would read the book. He thought Mr Hayward's entry was helpful.

Response/resuscitation

5.23 Ms Draper was critical in her report that the key to the treatment room in which the anti-ligature scissors were kept was held by one member of staff. If he or she was not present at the time, there could be a delay in obtaining the scissors. Ms Draper noted the circumstances in which the scissors did arrive in D's cell and that the "delay could have been disastrous". However, "given the eventual outcome ... this is probably not the case on this occasion." (At the time Ms Draper carried out her investigation, it was believed wrongly that D had made a full recovery.)

5.24 Ms Japaul told us that the emergency bag containing life saving equipment was kept in the emergency room on R1 and checked every morning. Ligature scissors were kept in the bag. Staff finding a medical emergency would immediately call the alarm by shouting or pressing the bell. They would then wait for someone to arrive before entering the cell. (There were occasionally hoaxes and staff safety had been compromised. In any case, agency staff did not carry keys.) On entering the cell, someone would immediately support the body if it was a hanging. Ms Japaul said there was basic training on what to do in such eventualities during the suicide prevention training.

5.25 Mr Leane explained that no-one in the prison carried 'fish-knives'⁷³ at the time. He did not know where the scissors were brought from. It might have been the shadow board,⁷⁴ but in any case there would have been some delay. He suggested it could have been three, four or five minutes before they came. The medical bag was just thrown into the cell.

5.26 He said at the hearing that staff called for scissors but that it was difficult to gauge how long they took to arrive. He did not know who brought them. He explained that there was no particular significance to his use of the word "eventually" in his incident report.

5.27 Mr Richards said Mr Leane was trying to get the noose off, but it was very tight. He said it was seconds (or at least within a minute) that the scissors arrived. He remembered the bag being flung from the door and explained that it was not possible to fit many people in a cell. He said everything happened in a flash and he could not believe there would have been a three to five minute delay until the scissors arrived.

5.28 Mr Murray could not remember any delay in obtaining cutters.

⁷³ Fish knives are specially designed so that they can cut through ligatures but cannot be used as a weapon. I have recommended in numerous reports on self-inflicted deaths that all front-line staff should carry them and this has now been adopted as Prison Service policy.

⁷⁴ Potentially dangerous equipment is kept in a cabinet with the shape of each item marked in shadow to enable immediate identification of anything that has gone missing.

5.29 At the hearing, Mr Hayward said he ran into the cell to find two officers holding up D from the floor. He jumped on the bed. Four of them were supporting the body, but Mr Leane was unable to remove the ligature. Mr Hayward shouted to a nurse to fetch the scissors. The nurse went away and came back to say she could not find them. He said they were in the emergency bag. She asked where that was and he told her. She fetched it and threw the bag into the cell. Mr Hayward then retrieved the scissors. He said he thought she was a full time nurse, but could not recall who it was. He agreed that the episode had not been very satisfactory, but thought the time between his arriving in the cell and having the scissors to hand was only between 20 and 30 seconds. He did not recall it being five minutes. Mr Hayward explained that the emergency bag was kept in the treatments room – one of the old AS rooms. This was about three doors away from the office, which was itself about three doors away from D’s cell. He estimated it was about 10/15 yards. He said a ligature cutter was also kept in the key safe in the treatments room on the same side of the landing as D’s cell. The nurse might have looked there first. He said there were two, perhaps three, pairs on the landing, but that the ones used were those in his emergency bag.

Consideration

5.30 Ms Stern was critical of the role played by Nurse Chikuku on 27 December. She said:

“... it appears that Nurse Chikuku was not properly exercising such professional skill on the day of 27 December 2001. Her attitude to observation, and her appreciation of the importance of engagement, clearly fell short of the standard described by Professor Rogers ... Her job was, of course, made all the more difficult by her lack of previous contact or relationship with D, and having to observe from outside a locked door. Nurse Chikuku’s lack of experience ... meant that she was even more in need of detailed supervision and care planning – and her lack of experience showed markedly in her approach to her task on 27 December 2001.”

5.31 Professor Rogers’ criticism was stronger. He said the observation nurse had a personal professional responsibility to ensure she saw the support plan. He suggested that not to have done so amounted to professional misconduct. He said the nurse in charge should also have ensured that she read up on the prisoner.⁷⁵

5.32 This is strong criticism, which I share in part. Bearing in mind that a significant part of Ms Chikuku’s role was to interact with D and assess his state of mind, it is difficult to understand how she could do her job properly without any knowledge of him. It meant that she was not aware of his particular issues nor of events that might indicate that the level of risk was

⁷⁵ Professor Rogers explained that the guidance on carrying out observations to which he had referred was issued in 1999 by the Nursing and Midwifery Council to enable formulation of local policy. He was not sure it would have been disseminated to prisons.

raised. In this, however, I am equally critical of the quality of the Prison Service handover.

5.33 Turning to the finding of a noose and razors, Mr Eadie suggested in his closing statement that appropriate action was taken. He said:

“... it is evident that this discovery was taken seriously – D was asked for and proffered an explanation, a record was made of both in the F2052SH, he remained on 15 minute documented watch.”

5.34 Ms Stern took a contrary view. She said of the cell find:

“There was a clear lack of awareness of this incident on the part of those making decisions in relation to D on that day, notwithstanding that he had a prior serious attempted hanging using a sheet as a noose. This was a significant indicator of serious risk of self-harm.”

5.35 From what Ms Draper said, it does seem that someone spoke to D about the find. Ms Draper did not record whether this was Mr Richards or whether a senior officer spoke to D after Mr Richards reported the matter. Certainly, I would have expected the senior officer to have done so in order to assess D’s state of mind and whether there was heightened cause for concern. However, Ms Draper noted that there was no record of any action taken as a result of the find. I infer from her criticism that this incident (and D’s statement that he would die that night on 25 December) should have been “followed up by senior staff and further assessments made as to if D posed any increased threat of self-harm”, that it was only Mr Richards who spoke to D. This was unacceptable given that D was still at this point considered to pose sufficient risk to warrant 15 minute documented observations.

5.36 The question is whether any further action should have been taken in light of the find, notwithstanding D’s response when questioned. Unfortunately, there is no evidence that the matter was even considered.⁷⁶ Mr Richards suggested that it was not unusual to find razors in prisoners’ cells and D’s explanation was not on the face of it unreasonable (according to Ms Draper, D had said they were for cutting matches). Mr Hayward said it was not even that unusual to find nooses (according to Ms Draper, D had said the noose was a joke). Given that D had enjoyed a period of relative calm such that he does not appear to have come to the particular attention of staff during the preceding two weeks, it was perhaps not unreasonable to take his explanation for the razors at face value. In addition, he was already on a 15 minute documented watch.

5.37 However, the finding of a noose must on any reading be a matter for concern. I cannot of course know what D’s demeanour was when he said it was intended as a joke, nor do I know if such ‘jokes’ were in character. But it would have been an odd joke in any circumstances. Given that D had

⁷⁶ By this I mean not that documents have gone missing, but refer to Ms Draper’s comment that there was no record of further action.

previously attempted to hang himself, the failure to take any extra precautions was very dubious.

5.38 Dr Cumming suggested that it was possible that D wanted the noose and razor to be found on 27 December. I infer he meant it may have been a cry for help. However, this does not mean that the find was not significant. On the contrary, if Dr Cumming is right, it means D offered staff the opportunity to help him but they did not take it.

5.39 Ms Chikuku could not recall at the hearing whether she was aware that D had previously covered his cell flap before cutting himself. It is of course not possible to know how she might have interpreted his behaviour if she had known, and/or if she had been aware of the cell find that morning. The officers to whom she reported the matter might have been aware in that there was an entry about it in the observation book. However, it is questionable whether staff could reasonably have been expected to recall an incident that had happened over three weeks previously in a busy prison wing.

5.40 Should the act of covering his cell flap have prompted staff to take additional precautions with D? It is quite common for prisoners to try to secure their privacy by covering the flaps in their cell doors. In this respect, there may not have seemed anything remarkable about D's behaviour; covering the cell flap is a familiar part of prisoner culture, albeit one with evident implications for safety and control. Unfortunately, we do not know whether this behaviour was typical of D or whether the only other instance of him covering his cell flap was on 3 December when he self-harmed. Nor do we know what action staff took – that is, whether they simply reiterated Ms Chikuku's instruction or whether they had a conversation with D about what he was doing. I do not believe there is sufficient information on which to base a judgement on this point.

5.41 With the benefit of hindsight it is easy to say that, taken together, the fact that D was considered to warrant 15 minute documented observations, the finding of the noose and the repeated attempts to stop people seeing into his cell, meant staff should have taken action. However, I am not certain this is a fair conclusion at this distance in time.

5.42 The final piece of the jigsaw that may have indicated what was to come was when D smashed up his locker during the lunchtime period. Physical violence to his surroundings had been associated previously with episodes of self-harm, but staff did not make the link. They rightly identified that he was frustrated (and took action, they thought, to address his frustration), but were not alert to the outcome to which such frustration might lead. Once more, however, given the behaviours with which they dealt on a daily basis, I am not sure it would have been reasonable to have expected them to make this link (even if they had been psychiatrically trained – see Ms Stern's comments below).

5.43 It is important to remember too that D was on 15 minute documented watch. This was the second highest level of intervention. Constant watch

would only normally be invoked when the risk appeared acute. On balance, I do not believe staff should be criticised for concluding that D's behaviour on the morning of 27 December was not such as to justify a constant watch.

5.44 Turning to the granting of the phonecall, Professor Rogers suggested that D's reaction to his daughter being taken into care could have been predicted, purely on the basis of what D had told staff. He was critical of the absence of a plan to address the issue. He noted that Mr Hayward allowed the phonecall, "despite the potential seriousness of the information D may be finding out," and that it was "quite clearly evident" that no management plan had been set up for this contingency.

5.45 Professor Rogers acknowledged at the hearing that it would have caused D frustration and anger if the phonecall had not been given. But he maintained that, if staff had known that D was expecting news about his child, they should not have allowed it. He suggested that if they did not actually know what the call was to be about, there were nevertheless signs that D was preparing for bad news. In that light, staff should have quizzed D about what the phonecall was to be about. It was a risky decision to give it whether or not they knew its likely content.

5.46 Ms Stern described the decision to allow the phonecall as "misguided", given the lack of a clear management plan in place in the event of bad news. (She suggested that there was evidence that Mr Hayward was aware when granting the call of its likely subject matter.)

5.47 On the other hand, Dr Cumming considered the (unwonted) decision to allow the phonecall on 27 December, notwithstanding D's disruptive behaviour, as further evidence of an attempt to address risk and "an act of beneficence". He added that D had a right to have the phonecall.

5.48 Mr Eadie suggested that the intention "was to assist D, and to diffuse a potentially difficult situation." There was "nothing to indicate that the officers concerned knew in advance that the call to his girlfriend would be likely to bring bad news." He pointed out that Mr Leane's original understanding following the call that D's daughter had died was evidence that they did not know beforehand about the possibility of her being taken into care.

5.49 Whilst I have some concerns that the person who made the decision to allow the phonecall probably knew very little about D or his circumstances, I agree that the decision itself was the right one. It is important that any strategy for dealing with self-harm does not strip the prisoner of all personal responsibility. To a large extent, the decision to make the phonecall was D's and it was a choice he had the right to make. (It is also worth bearing in mind that, had he possessed a phonecard, he could have made a call without staff's knowledge.) In the circumstances, to have denied D the phonecall could have caused him intense frustration; indeed, the result might well have been the same. D was an adult, he wanted a phonecall and it was right to allow it.

5.50 It seems to me that the more pertinent questions relate to actions taken (or not taken) by staff afterwards – in particular, whether D should have been placed on constant watch. ‘Caring for the Suicidal In Custody’ said:

“Actively suicidal prisoners should be given continuous 24-hour support by nursing staff or trained befrienders. A ‘15-minute watch’ is totally inadequate during the acute phase of the crisis.”

However:

“Prisoners at lower risk should not be continuously supervised. There is a danger of prisoners feeling ‘crowded’ by staff, which may be counter-productive and increase suicide risk. The prisoner needs to retain some privacy and control ...”

Was cost a factor in D’s care?

5.51 Professor Rogers expressed concern about why D was not put on constant watch. He commented that Mr Hayward did not actually answer Ms Draper when she had asked whether he had considered changing the level of observations. He was also critical of Mr Hayward’s suggestion that putting everyone who was a bit vulnerable on constant observations would have resulted in “a whole landing of agency nurses,” and suggested this might have been an inhibitor to putting D on constant watch. He commented that:

“If prisoners need constant observation, then it should be provided irrespective of how many agency nurses are on the landing. The need to preserve life should come before any other consideration. I do not understand why, if it is deemed necessary, based upon the identified risk that a person poses and that risk alone, why the whole landing isn’t full of agency nurses if it is deemed necessary. It suggests that SO Hayward is operating some sort of screening process as to how many agency nurses should be present irrespective of the prisoner’s need. I am not sure what criteria SO Hayward uses to make these decisions, or indeed, what training he has had on clinical risk assessment to assist him with his decision making.”

5.52 Mr Leane had suggested to Ms Draper, and repeated to us, that cost was a factor in determining whether someone was put on constant watch. He told the inquiry that the number of constant watches seemed to increase around the end of 2001, as they ensured prisoners were physically safe. They had to be authorised by doctors or perhaps managers because agency staff had to be brought in and “it was all about money”. Mr Leane said he never heard this said specifically, but it stood to reason that if you had a member of staff employed solely to watch one prisoner it would cost a lot. However, he also said he had not come across any instances where someone was not put on constant watch when it seemed to him they should have been.

5.53 Mr Hayward said the reduction in the number of agency nurses had no bearing on decisions relating to constant watches. He said cost was a

constraint, but it never prevented them from effecting constant observation where this was identified as being necessary. He advised that enhanced watches were implemented immediately they were needed. If there were insufficient staff to carry them out, an area of the regime would be dropped pending the arrival of an agency nurse. (This could sometimes be for the duration of an entire shift.)

5.54 I asked the former Deputy Governor, Ms Kringle, whether cost was a factor when considering whether to place someone on constant watch. She said she did not think the cost of agency staff meant that constant watches were avoided. She thought the prison ran up enormous bills rather than cut the number of watches.

5.55 The former Governor, Mr Davies, was more equivocal. He acknowledged that the cost of constant watches linked in with the agency nurse issue, as this was something agency personnel would do. Mr Davies said it took him a long time to work round this – both because he had “other fish to fry” and because it was sensitive. He said someone simply sitting staring through a glass pane was not the best use of resources, but it was effective. (This was one of the reasons why Dr Yisa wanted dormitories.) Mr Davies pointed out that, since the prison had been over budget every year for five years, it was not going to be overly constrained by budgetary consideration in relation to constant supervision. If constant supervision was necessary, it was authorised.

5.56 I judge from this that cost was a factor in people's minds at the time. In a world of finite resources, how could it be otherwise? However, I get no sense that D was not placed on constant watch for financial reasons – even sub-consciously. Mr Hayward was quite clear that he could – and would, if he thought it necessary – place a prisoner on constant watch. Any sticking point, if there was to be one, would have been in having the decision authorised retrospectively.

What more could or should have been done?

5.57 Ms Draper noted that, although written entries had been made warning staff to be extra vigilant after D's phonecall, “it does not appear that this development was passed on to the nurse who had been given specific responsibility to supervise [D], albeit other staff had been advised.”

5.58 Nurse Chikuku said she was not consulted before the phonecall and not told about it afterwards. She did see D being returned to his cell but no-one had told her to be vigilant. She said she did not actually enter the cell to talk to him when he returned and that he did not want to talk.⁷⁷ She said he was not distressed, but was just the same as he had been before (this might be considered to vindicate Mr Hayward's inaction with regard to constant watch). D did not tell her anything about his phonecall. She said that, had

⁷⁷ Ms Chikuku told Ms Draper that D's neighbour told her that D had said he was going to do something stupid and that he was really down about the phonecall. She confirmed at the hearing that it was only after the incident that he told her this.

either staff or D told her about the phonecall, she could have asked for constant observations or tried more to interact with him. She could not be certain about timings, but thought there had been sufficient time for officers to tell her what had happened and allow her two or three minutes to chat with D.

5.59 Dr Cumming noted that, although the evidence was not clear, it seemed from her comment that D did not want to talk that Nurse Chikuku had tried to engage with him after the phonecall. He queried whether it would have made any difference if she had been informed about the content of the phonecall as, “there seems a good possibility that D would not have wanted to talk.”

5.60 Dr Yisa said that, if the patient would not engage, then the nurse must break his isolation by bringing his/her training and experience to bear. It was important not to give up but to persevere. Dr Ranaweera agreed. She said that nurses should try to engage with the prisoner even when the prisoner was not keen.

5.61 Professor Rogers agreed too. He pointed to the absence of a care plan that should have informed the way the nurse carried out the observations. The key was the level of interaction and being able to break down barriers with the patient. He noted the difficulty of achieving this in a prison with locked cells and observed that staff in the NHS were not allowed to put an at risk person behind closed doors. The care plan should have specified how to break down the barrier. In addition, someone who knew the patient should have been used for the observations. The very fact that the nurse carrying out the observations did not know D created difficulty. In the event that there was no care plan and the nurse could not engage with D, she should have asked for advice.

5.62 Ms Stern noted that D apparently told his neighbour about the phonecall and suggested that, “had there been a proper and meaningful engagement within someone D knew and trusted, there is a real prospect he would have shared this information with them.” Practical steps could then have been taken to help him to cope.

5.63 Dr Yisa said the options available on 27 December were to discuss the matter with D and place him either in the ward or on one-to-one observations. He said there should also have been a discussion between nurses and doctors.

5.64 Professor Rogers was critical of D’s management generally after the phonecall. He asked what staff were precisely supposed to infer from an instruction to “keep an extra eye on him” and suggested that it was in fact “pointless”. He said he would expect the observing nurse to have been told about the phonecall, and suggested that verbal communication with her following the phonecall should have taken precedence over the written record. (Although at the hearing Ms Chikuku could not remember whether she was told about the telephone call, she told Ms Draper categorically that no-one had told her.)

5.65 Professor Rogers argued that the phonecall was sufficiently significant to require more than simply returning D to his cell. Bad news was a very significant trigger to self-harm. He suggested that Mr Leane could have summoned help on his way past the office, the nurse doing the observations could have been asked to increase them, other nurses should have been told, consideration given to using the AS cell, and the doctor should have been called. Professor Rogers suggested that staff should have avoided isolating D, perhaps keeping him with a member of staff or by giving him access to the ward area. This was important in light of the fact D had been indicating he did not want to be observed. Professor Rogers acknowledged that D might present a risk to others, but said the risk of suicide should have been the primary concern. He stressed that, until there had been a chance formally to revise the care plan, D should not have been isolated. He should have been watched constantly while something was sorted out.

5.66 Professor Rogers said this was not a question of the benefits of hindsight. He said D was fairly distressed and Officer Leane was concerned enough to tell SO Hayward. It was obvious that D had had bad news and there was a clear link to his self-harming behaviour. He suggested that, if it was not possible to consult with the medical officer before the phonecall, he should have been consulted in light of D's reaction.

5.67 Ms Stern summarised this as follows:

“Against the backdrop of what was known of D, the act of leaving D in his cell, locked in, with only 15 minute supervision through the locked door by an agency nurse with whom he had no established relationship after the receipt of bad news in relation to his daughter, was the clearest possible failure to take the care required in the circumstances ...”

She was critical that the officer who made decisions about D after the phonecall knew little about him. She said:

“To [Senior] Officer Hayward ... D was just another face on the landing whom he did not know very well, having taken leave leading up to Christmas 2001 until 27 December. He would not routinely have read the IMR, and he probably would not have looked back beyond a couple of days of D's history. He could not recollect if he was aware of D's earlier hanging attempt on 13 December.⁷⁸ Thus, the clinical decision maker had no proper training in management of those at risk of self-harm, and did not have available to him information relevant to the assessment of D's risk. This shows the need for a proper and detailed care plan and proper systems of communication of clinical information.”

She listed other actions that might have been taken (similar to those suggested by Professor Rogers), but added:

⁷⁸ Ms Stern drew this information from Mr Hayward's evidence at the hearings.

“None of those options was even considered. Instead, D was left in the situation of maximum risk. It cannot be doubted that, if not left alone, D would not have been able to hang himself when he did. “

5.68 Ms Stern was critical of the lack of psychiatric training (a point I return to in Part IX). She said the difficulties caused by the lack of detailed psychiatric training were clearly evident from Senior Officer Hayward’s response to D’s distress after the telephone call (when he had talked about “a whole landing of agency nurses” and added, “Knowing D from what I did, he was always a little bit demanding as such.”) Ms Stern said:

“This shows both the lack of psychiatric training, lack of skilled observation skills ... the lack of appreciation of risk, and the lack of communication. All of this may well have been altered if there had been proper instructions from a psychiatrist, proper care planning, proper communication, and proper training.”

She added that, in the absence of a definitive view having been reached about D’s mental health, staff should have erred on the side of caution. She described leaving D “alone and isolated” as “plainly a gross lack of care”.

5.69 Mr Eadie noted that evidence differed as to D’s demeanour after the call, but said that, “It seems probable, and natural, that he was upset and may well have been tearful.” However, he suggested that Mr Leane had acted appropriately in returning D to his cell, “He did not regard it as his role to make decisions about what steps to take in relation to D. That was both understandable and correct.” Mr Eadie added:

“It would be difficult indeed to criticise Officer Leane for not alerting Nurse Chikuku to the call before going to see [Healthcare Senior Officer] Hayward – first, because it is far from clear whether or not he did so; secondly, because Nurse Chikuku evidently appreciated that D, who she knew had just had a call, was upset on return.”

5.70 Professor Rogers was asked whether medication could have been available to be administered by nurses as required. He confirmed that it was and that D was the sort of patient for whom such an arrangement might be appropriate. He suggested that such medication might reasonably have been administered after D smashed up his cell.⁷⁹ Professor Rogers said that, in the NHS, they would probably have restrained D in order to administer the medication. This was possible in common law (and therefore open to prison staff), but was not ideal practice.

5.71 However, Dr Cumming advised that it was rare to restrain someone to sedate them in a prison. It happened perhaps twice a year at HMP Belmarsh where he worked. It was not something to be undertaken lightly and only where there was immediate danger. He would also expect a psychiatrist to be

⁷⁹ It is worth noting, however, that cell smash-ups in prisons are not infrequent.

involved (even though there was no link to the Mental Health Act). There was nothing to suggest this was warranted in D's case.

5.72 Dr Cumming said the period 25-27 December was a worrying time. Christmas was always a time of heightened vulnerability and 25 December was also D's birthday. In addition, D had said he was going to kill himself. This was relevant to the assessment of risk on 27 December. The events of that morning showed that D was getting frustrated and wound up. Blocking his cell flap was potentially a cause for concern. This could sometimes be quite a provocative act but there were other possible explanations. It was not possible to know without talking to D, but it would be foolish to say it was not relevant.

5.73 Dr Cumming compared events on 27 December with those of 13 December, when, he suggested, returning D to his cell when he was agitated and frustrated might have exacerbated his state of mind and led to the suicide attempt. He was unwilling to agree that events of 13 December should have alerted staff to the dangers of returning D to his cell, and suggested that there was operationally perhaps little other option. The only certain way of preventing a suicide attempt would have been to have placed D in a gated cell. The alternative might have been to put him on constant watch, but Dr Cumming did not consider this was warranted on the facts. He suggested that such a decision would have been "unlikely" without first involving D, but D did not want to talk. In addition, Nurse Chikuku had given evidence that there was little difference in D before and after the phonecall. Dr Cumming concluded that the most sensible option might have been to talk to D for a while and provide a Listener immediately, or provide him time out of his cell and interaction with other prisoners.

5.74 Dr Cumming said it was a 'given' that bad news or needs not being met would lead to self-harm. Even so, he could not say that D should not have been returned to his cell on 27 December. Staff needed to manage D in the particular environment. Nevertheless, he hoped those managing the situation on 27 December would have been aware of the events of 13 December – and more generally, D's history since 30 November.⁸⁰

5.75 According to Dr Cumming, there was a lot happening after the phonecall and the timescales were not clear. The only guarantee against self-harm would have been constant watch. Getting the medical officer down would not necessarily have been helpful in the time available. It would not have been appropriate to have put D on the ward because of his challenging behaviour. Someone should have talked to him, but the choices were limited in a prison as opposed to a hospital. Constant watch would have been the surest option, after which came someone talking to D. Dr Cumming agreed something ought to have been done.

⁸⁰ Mr Morton suggested at this point that two weeks was a relatively short time, and that the two events would seem on the face of it to be related.

5.76 The validity of that conclusion depends on both the perceived need to engage D and the time there was to do so. Mr Hayward could not recall procedures with regard to authorising 24-hour watches, but thought that whoever was in charge of the landing could do it. He said staff were given quite a bit of autonomy and would act first and answer any questions later. Certainly, he did not suggest he felt constrained in any way. However, it is unclear whether he considered this option in this particular instance. I infer from Mr Hayward's descriptions of D's demeanour following the phonecall that he probably did not, as D's behaviour did not appear to warrant it. It would not be appropriate for me to second guess that view, given that I was not there and did not see D. It is also pertinent that D was on the second highest level of observation. However, it might well have been sensible to have gone to speak to D in order to reach an informed judgement – although, by Mr Hayward's account, there simply was no time for this. (I discuss the likely timings below.)

Timespan

5.77 Ms Chikuku thought everything had happened in a short space of time. Her statement to the inquiry had said about ten minutes had elapsed between the phonecall and her discovery of Mr D. However, her earlier statement for Ms Draper's report had been ambiguous on this point (referring separately to gaps of ten minutes and thirty minutes). She could not say at the hearing which was nearer the mark.

5.78 There was considerable discrepancy between Mr Leane's and Mr Hayward's accounts of the timeframe. Mr Leane thought the alarm was raised about 30 - 45 minutes after he returned D to his cell. Mr Hayward said the alarm was raised as he put his pen down after writing the entries in the observation book and the F2052SH. He said it was only about half a minute – “almost instantaneous”. Mr Hayward could not account for the timings offered by Mr Leane. He said it was “text book” – he wrote the two entries and then the alarm sounded.

5.79 Mr Eadie favoured Mr Hayward's recollection of the timespan involved. He noted that, although Mr Leane said in interview that the period might have been 30 - 45 minutes, he said at the hearing that he was not sure about timings. Mr Eadie noted that Ms Chikuku was also uncertain about timings, but she had also recalled that the discovery was made during her first check following the phonecall. On the other hand, Mr Hayward was consistent and quite clear. Mr Eadie suggested that Mr Hayward's evidence about the immediacy of events was bolstered by what Mr Hayward said he would have done, if he had had the time. Given Mr Hayward's evident concern about D, “the fact that he did not have the chance to do them is powerful support for his recollection of the timings.” Mr Eadie went on to say:

“It would not be appropriate on the evidence to fudge this issue by relying on a range of timings. Officer Leane's reference to 30 - 45 minutes cannot stand alongside the other evidence, including his own. Nurse Chikuku's ten minute reference was a maximum not an estimate

– and in any event, [Mr] Hayward’s recollection is stronger and more soundly based than hers.”

5.80 Ms Stern took a contrary view. She said in her closing submission:

“The timings on the 27 December 2001 are not entirely clear. Officer Leane’s timings in his interview with Carol Draper appear the most precise. He returned to the healthcare centre at about 2. Gave LD 10 minutes to calm down, then took him for his phone call. LD was on the telephone for maybe about 5 minutes, then was returned to his cell. He was found hanging by Nurse Chikuku at around 1545. There was clearly some gap between the phone call, and the hanging. Nurse Chikuku said to Carole Draper that the attempted hanging was 30 minutes after the phone call. Officer Richards also said to Carole Draper that his recollection was that the phonecall was about ½ hour before the incident.”

5.81 My judgement is also that Mr Leane’s account is nearer the mark. In the first place, Ms Chikuku said she had checked D ten minutes before returning to find his cell flap covered. The earlier check (that is, the one ten minutes before the final one) was in my view more likely than not to have been after the phonecall, because ten minutes would not have been sufficient for D to have made his phonecall and returned to his cell, formed a noose and threaded it through the light-fitting – no easy task, given its location. In addition, she referred to D not wanting to speak after the phonecall. Clearly, she could not have said this if the only time she saw him after the phonecall was when she found him hanging. (I should stress that I am not suggesting that Mr Hayward has deliberately misled the investigation in any way, and I am sure he is being faithful to his own memory of events. However, he himself has described 27 December 2001 as a “fraught” day. I suspect he may simply have been distracted and misjudged the passage of time.)

5.82 This suggests that, at the very least, there was a ten minute window of opportunity. I judge that it was probably longer. Mr Leane said that he gave D ten minutes in which to calm down after returning from lunch at between 2.00 - 2:10 pm. Assuming that only 10 minutes elapsed, D would have been taken for his phone call at about 2:20 – 2:25 pm. Even if he took 20 minutes on the phone (Mr Leane told Ms Draper it was a five minute call), he would have returned to his cell by about 2:45 pm. (In his interview with Ms Draper, Mr Leane said he thought Mr Hayward’s entry was made in the observation book at about 3:00 pm). Ms Chikuku raised the alarm at about 3:45 pm.⁸¹

⁸¹ Ms Draper said D smashed up his cell at 3:00 pm. Using the same timings set out above, this would make the timespan between D returning to his cell and being found hanging much less, but still significantly more than the ‘almost instantaneous’ of Mr Hayward’s evidence. (I should stress that I am not suggesting Mr Hayward was not being faithful to his own memory of events. It is easy to mistake timings after any incident, and especially in a pressurised environment such as the healthcare centre. I suspect he was busy and not aware of the passage of time.)

5.83 This means there was a significant timeframe in which to have intervened or at least for Mr Hayward to have spoken to D to form a judgement as to need. Given his estimation of the timings, it seems likely that he was very pressed. It may be, as I have said, that he was distracted by some other occurrence. I am not suggesting that he made a conscious decision not to go to speak to D. Indeed, everything points to him being an extremely conscientious and professional officer. However, Mr Hayward may have under-estimated the likely implications because of his lack of familiarity with D. It should be remembered that D had enjoyed a relatively settled few days, so there would have been no reason specifically to bring him to the senior officer's attention. It is also possible (though not certain) that there were no entries in the observation book about D for the previous week. However, I would have expected Mr Hayward to have read D's F2052SH and to be aware for that reason of his vulnerability. Whether the F2052SH referred to D's anxieties about his child is not known.

5.84 Summarising events of 27 December, Mr Eadie said:

“... there were a limited number of choices. Should he have had a phone call (plainly yes)? Should he have been supported beforehand (no – because, on a proper analysis of the evidence, no-one knew about the child into care risk)? Should Officer Leane have returned him to his cell (yes – there being no association at that time and the decision to return him for the short time and in the knowledge that he was on 15 minute documented watch whilst he talked to [Mr] Hayward being an eminently reasonable one)? Was there time to implement any different plan thereafter (no – if [Mr] Hayward's evidence is accepted, which it should be for the reasons set out above.)”

Mr Eadie said the issue was not about whether decisions made were right or wrong but about whether they fell “within a reasonable range (excluding hindsight)”. He added that particular care was needed when assessing this, especially in light of the fact the IMR was missing.

Resuscitation

5.85 In relation to the scissors, Mr Eadie suggested that any delay in obtaining them was not substantial. He noted that both Mr Hayward and Mr Richards said they arrived within seconds or “under a minute” and that, although Mr Leane originally suggested it might have taken three to five minutes, at the hearings he said it could have been 30 seconds. Mr Eadie also suggested that the very fact of D's resuscitation indicated he could not have been hanging for a significant period of time.

5.86 Ms Stern considered the delay was probably longer. She said three to five minutes was more likely to have been the time taken, “to shout once for the scissors, then not to come, then shout for the bag, then wait for someone to open it, then have to get down to open it.” She said this, “had a real prospect of making a difference to the brain injury caused to D.”

5.87 D's representatives wanted me to obtain expert advice on the likely effect of any delay in cutting D down. I declined. It stands to reason that the quicker a ligature can be released, the better the chance of a complete recovery. The extent of the damage suffered by D is clear evidence that intervention was not speedy enough to prevent serious brain injury. However, there is no way of knowing how long D had been hanging before he was discovered. Any subsequent delay in obtaining scissors with which to cut the ligature might therefore have been marginal or irrelevant. I can say nothing more than that any delay in obtaining the scissors (and two witnesses said the delay was no more than seconds) was self-evidently unhelpful and very regrettable.

5.88 Mr Eadie submitted that:

“... the reaction of the prison officers to the emergency was highly commendable. The degree of professionalism shown was in large measure due to the dedication and training efforts of Senior Healthcare Officer Hayward ... There can be little doubt that the efforts of Senior Healthcare Officer Hayward, Officer Leane and Officer Richards saved D's life ...”

I agree. One of the few certainties to have emerged from this inquiry is that, once D was discovered, staff reacted swiftly and professionally. That those who attended to D were trained in trauma techniques was critical to his life being saved. Each of the officers is to be commended – particularly Mr Hayward who led the resuscitation and was responsible for the Hotel 9 initiative.

Conclusions

5.89 My own view is that D's actions in covering his cell flap and smashing his locker, while lent particular significance (and attention) in light of his attempted suicide on 27 December 2001, were not in themselves remarkable in a prison context. Prisoners constantly try to secure their privacy, and smashing up of their surroundings is a depressingly commonplace reaction by impulsive young men to the frustrations of prison life. D was no different in this respect. I am less willing to discount the finding of the razors and noose, notwithstanding evidence from staff that such finds were not unusual. That may well have been the case, but D was considered to be sufficiently at risk of self-harm to warrant the second highest level of observations. Something should have been done in response – at the very least a manager should have spoken to D and the matter should probably have been reported to his doctor.

5.90 As I have said, I consider the granting of the phonecall to have been proper and humane. Nevertheless, I consider there was time afterwards to have intervened in some way. Evidence about D's demeanour after the phonecall is inconclusive and does not of itself clearly indicate whether further action would have been warranted. However, D's history (and written records) made it clear that bad news about his daughter was likely to trigger

an act of self-harm. In the circumstances, I do not consider that a written note for staff to be vigilant was sufficient.

5.91 I consider the response to the discovery of D's attempted suicide to have been first class.

Hotel 9

5.92 Mr Hayward said staff were not ordinarily trained in what to do in trauma cases – trauma was an entirely separate discipline to other medical training and went far beyond basic first aid. He said he had first formulated the training in 1997, but it had then sat gathering dust before he pushed it through on his own initiative (with the support of Mr Davies). He said he delivered the trauma course to new officers on the centre as well as some nurses. Between 18 - 20 people were trained and Mr Hayward acted as team leader whenever he was on shift. Mr Hayward thought the Hotel 9 team at Pentonville had probably been called into action four or five times per week, dealing with a whole range of incidents.

5.93 It could take between 20 minutes and one hour for an ambulance to reach the prison gate. It had to get through to a secure location and the team then had to make their way to the scene. Those who could be on an operating table already prepared within an hour had the best chance of survival. The Prison Service wasted too much time simply waiting for ambulance staff when they could be preparing the casualty.

5.94 Apart from training staff in resuscitation techniques etc, Mr Hayward also established a protocol with regard to facilitating the attendance of ambulance staff – that is, in relation to escorts and exits and entry points. The trauma team was to be called to any incidents that were remotely life threatening. Mr Hayward had trained all the discipline officers for the team.

5.95 Mr Leane told the public hearing that the trauma training (for which he volunteered) lasted two or three days and included resuscitation, use of defibrillators etc. The trauma team attended any incident in the prison. He said he had only just completed his training when D attempted to kill himself on 27 December 2001. He could not recall how often they would have had to put their training into practice, but thought it could have been quite regularly.

5.96 Officer Murray spoke very positively about Hotel 9. He thought the training lasted one to two weeks and remembered that some of it took place in outside hospitals. They had covered, amongst other things, psychological problems, medication and use of the defibrillator. There were civilian nurses on the course too, and at the end they took an examination and received a formal, recognised qualification. Officer Murray described the training as "excellent". He could not remember how many times he had been called on to use his Hotel 9 training but thought the initiative was invaluable.

5.97 Ms Draper commented in her report that, "The training in resuscitation techniques given to staff is an excellent idea, and I have no doubt has led to

the savings of several lives.” She advised that appropriate and timely refresher training should be provided and that the whole initiative should not depend on one particular officer.

5.98 Mr Davies said Mr Hayward had already formulated the Hotel 9 initiative when he (Mr Davies) arrived at the prison. Mr Davies had already seen something very similar in the USA where they were dealing with an elderly prisoner population. He said Mr Hayward was therefore pushing at an open door and that the initiative eventually found favour more widely. Mr Hayward was subsequently detached to the Prison Service’s London Area Office to spread his programme to other jails. Mr Davies thought some London prisons had taken on the initiative.

5.99 Mr Hayward explained that the Area Health Adviser had taken the Hotel 9 initiative to the Area Manager and in 2002/03 it was given funding. He said some 134 people had been trained in trauma and the feedback had been extremely positive. It had been professionally endorsed by a variety of agencies. Apart from giving practical medical training – in using airways and oxygen, and what to do in cases of spinal, thoracic and abdominal injuries and major fractures – it trained people in how to formulate an emergency team. However, funding was subsequently withdrawn when it was deemed not appropriate for central funding and that PCTs should fund it instead. Mr Hayward found it impossible to deal with the range of PCTs involved and the initiative folded. He very much regretted this as Hotel 9 had answered a need in the Prison Service.

5.100 Mr Jonathan Warren, the current healthcare manager at Pentonville, submitted a statement to the investigation describing healthcare at Pentonville in 2007. He said a radio – Hotel 9 – was held by a member of the nursing team or a healthcare officer for emergencies. These were coded Level One and Two depending on the seriousness. All nursing and healthcare officer had accredited and up-to-date training on Basic Life Support; nursing staff “and where possible” healthcare officers also had training in Intermediate Life Support or its equivalent and all GPs “and where possible” Senior Nurses had accredited training in Advanced Life Support. All officers (but not healthcare staff) carried fish knives.⁸²

5.101 In his statement, Mr Hayward was critical:

“... this training does not include basic trauma care or the use of advanced trauma equipment and does not teach how pre-hospital care should be provided in the prison environment. It simply provides students with a basic knowledge of CPR and the use of the defibrillator.”

5.102 Mr Hayward told the investigation that all the officers (who were all Hotel 9 team members) reacted magnificently on 27 December. He could not have asked any more of them. (He said he thought their efforts were

⁸² It seems to me odd that healthcare staff, of all staff, should not carry the knives.

inadequately recognised within the prison, however.) At the public hearing he said it transpired afterwards that D had suffered a spine/neck injury as a result of his attempted hanging. He said that, if normal first aid procedures as opposed to trauma techniques had been applied, D would have suffered serious injury.

5.103 Sadly, there are many incidents of serious self-harm or attempted suicide in prisons every year. Although unacknowledged by the media or the public at large, the prompt and professional intervention of Prison Service staff is responsible for saving many lives. However, I fear that many of those who are called upon to act feel poorly equipped for the task having been training only in basic first aid. Mr Hayward spoke powerfully at the hearing of the value of having a patient ready for the operating table before he leaves the prison, thereby saving valuable time. Given the inevitable delays in ambulances reaching prisons (which are often in remote locations), and then obtaining access to the particular location within the prison, the benefits of having staff trained in trauma are self-evident. It is extremely disappointing that Mr Hayward's initiative has fallen into abeyance.

I recommend that the Hotel 9 initiative is resurrected, properly funded, and consideration given to its introduction throughout the Prison Service.

PART VI – THE PRISON

Independent contemporary assessments

6.1 Because of the lack of records relating specifically to D's care whilst at Pentonville, it is appropriate for me to draw inferences from the general standards and conditions that obtained at the time. If the prison was performing well in most respects, it would be fair to assume that it probably cared effectively for D. On the other hand, if it was a failing prison at the time, it would be fair to infer that it likely failed D in some respects.

6.2 However, one of the principal difficulties of conducting an investigation into an event that took place several years ago is in determining what general standards obtained at the time in relation, for example, to physical conditions, staffing, regime, healthcare and psychiatric services and suicide awareness. This is particularly the case with an establishment such as Pentonville, which has undergone enormous change in the intervening years. Quite simply, Pentonville today is not the Pentonville of 2001.

6.3 The best objective assessment of the prison at the time is provided by the respective HM Chief Inspectors' reports of their inspections in 1999 and 2002. Although the pace of change at the prison is difficult to gauge (and there were certainly improvements between the two inspections), Pentonville in December 2001 must lie on a continuum somewhere between the two.

Pentonville circa 2001

6.4 The two Chief Inspector of Prisons' reports described Pentonville as the prototype Victorian radial prison. It was completed and occupied in 1842 and has remained in use ever since within its original perimeter wall. The original radial residential block remains much as it was.

6.5 Pentonville was and is a local prison, serving its own designated Crown and Magistrates' Courts. It houses prisoners awaiting trial, those convicted but unsentenced, and sentenced prisoners.

6.6 In the preface to his report of the 1999 inspection, Sir David Ramsbotham noted a "refreshingly 'can do' attitude throughout HMP Pentonville that is in marked contrast to what we have found in a number of other large, overcrowded, under-resourced, inner-city, local prisons." However, he noted that, despite the best efforts of staff, they were unable to provide the desirable level of activity for prisoners. Like other London prisons, Pentonville was experiencing difficulties with the recruitment and retention of staff and, "as a consequence, [was] usually running short staffed".

6.7 A "good selection" of meals was provided to prisoners and they were "of a reasonable standard". However, mealtimes were considered to be unacceptable and in need of review. The Chief Inspector also noted unnecessary restrictions on kit issued to prisoners.

6.8 In the introduction to her report of a follow up inspection in 2002, Ms Anne Owers said that Pentonville was experiencing considerable difficulties with overcrowding and staff shortages. She welcomed improvements in healthcare, offending behaviour programmes and work with those withdrawing from drugs, but concluded that, “in most other respects, Pentonville was unable to meet our tests of a healthy prison.” Vulnerability and risk “were not properly identified” and the monitoring of those on F2052SH procedures “needed improvement”. There was inadequate access to showers, clean clothes and telephones, and out of cell activities were “unpredictable and unacceptably low”. Notwithstanding a rising total and turnover of prisoners and shortage of staff, “it is not acceptable to hold prisoners in conditions which fall so far short of standards of decency and activity.”

6.9 Ms Owers’ report went on to describe the regime for prisoners as “among the most impoverished we have seen,” and suggested that safety at Pentonville was being compromised by the high throughput of prisoners.⁸³

6.10 The inspection team was satisfied that staff/prisoner relationships were generally positive, albeit that they had been “stretched and tested by staff shortages, overcrowding and the general turnover of population.” However, the Chief Inspector repeated her predecessor’s concern that the four-day week attendance system for staff militated against effective prisoner regimes, efficiency and continuity of relationships between staff and prisoners.

2001 BoV report

6.11 In the introduction to its report, the prison’s Board of Visitors noted that Pentonville had an operational capacity of 1,175 with approximately 570 staff in post. Nearly half the population came from ethnic minority groups. Throughput remained very high.

6.12 In the body of the report, the BoV suggested that a basic regime should include:

- information at the outset about prison procedures;
- a regular routine;
- a decent amount of time out of cell, “a good part of it” spent on purposeful activity;
- regular provision of clean clothes, bedding and toiletries and proper access to the telephones;
- visits that could be arranged without fuss or delay; and
- wholesome food decently served to a reasonable timetable.

⁸³ The former Governor, Mr Gareth Davies, told us that there were about 43,000 movements per annum through reception at the time. This equated to 9,500 new numbers per annum. Of those, he said 13 per cent would have had acute psychiatric disorder (“normally defined as requiring treatment in a secure unit”), 95 per cent had high psychiatric morbidity normally caused by drug induced psychosis, 65 per cent had educational levels below key skills level 1, and 65 per cent would have taken a Class A drug within the previous three days.

The Board said the prison achieved only the last of these. They said “all the other requirements are being met only on an unacceptably ‘hit or miss’ basis”.

6.13 The Board’s report continued:

“Because – we are told – of manpower shortages – prisoners can rarely be guaranteed the promised routine on any given weekday, they are allowed out of their cell for far too short a period each day and week (and association is sometimes arbitrarily curtailed) ... The same problem obtains in relation to the provision of clean clothes etc. We receive repeated, and justified, complaints from prisoners that in some weeks on some wings there are no kit changes at all, prisoners are required to sleep without adequate bedding, and there are interruptions on other essential supplies.”

6.14 The Board reported that staff said they were demoralised and felt under-valued “by an ever-changing management”. Despite assurances that minimum staffing levels were met, staff reported that staffing was either at or below these levels, “with the inevitable effects on prisoners’ regimes”. The Board noted that this was often verified by actual numbers on duty at various times. They welcomed news of an impending recruitment campaign.

6.15 The Board concluded its report as follows:

“The vast majority of staff, both discipline and civilian, work hard to maintain a decent and humane regime in Pentonville. But it is not one which is sufficiently stable, and prisoners are in too many instances being denied some basic entitlements. Beyond that, the paucity of the financial and manpower resources made available to the prison impairs staff efforts to rehabilitate, as well as merely hold, prisoners. As a result, prisoners suffer and the prison is not able to play an effective part in the criminal justice system.”

6.16 The BoV also expressed its concern about the fabric of the building and its maintenance – “Roofs leak; showers don’t work (or only with cold water); telephones are often out of order.”

PART VII – HEALTHCARE IN PENTONVILLE

Independent contemporary reports

HM Chief Inspector of Prisons - 1999

7.1 In the preface to his 1999 report, Sir David Ramsbotham noted that “the greatest deficiency in Pentonville remains the lack of a proper healthcare centre”. He commented on the failure of plans for a new healthcare centre:

“However, the Government then imposed drastic cuts in capital funding on the Prison Service, with the result that the plan was suspended, and, five years on, the healthcare centre is still temporarily housed in unsatisfactory accommodation.⁸⁴ To make matters worse, the numbers of mentally disordered prisoners in the healthcare centre make it one of the largest medium secure units (MSU) in the country, with a staffing ratio of 1 staff to 10 patients as opposed to 6 staff to 1 patient in an MSU. This gross understaffing, coupled with the antediluvian conditions in which patients are held, is compounded by the fact that, along with every other prison in the system, no healthcare needs assessment, as required by the Prisons Board to have been carried out by July 1997, had been completed. Nor had any action plan following our July 1998 inspection.

“The simple and stark facts are that laid down Prison Health Care Standards are not being met, in a variety of ways ... I am not surprised that morale was low amongst those staff who had to work in such conditions. I will not mince words. Healthcare arrangements at Pentonville are a disgrace, which should never have been allowed to happen ...

“I am appalled that such a necessary rebuild should have received such a low priority over the years, in view of what the delay has meant for the treatment and conditions for both staff and patients.”

7.2 The Chief Inspector said the healthcare centre was located:

“... in an entirely inappropriate building and was poorly managed and many prisoners were inappropriately placed as in-patients when they did not need 24-hour nursing care. Further, in-patients had an extremely restricted regime, which failed to meet the Prison Service’s required standards.”

The Inspectorate reported that there were no dayrooms or rooms for therapeutic occupation and that any such activity had to take place on the open landing. There was only one television set for all three landings, “though in the time that we were in the [healthcare centre], cleaners were the only

⁸⁴ The bespoke healthcare centre had been evacuated following the discovery of asbestos there.

prisoners seen to watch television”. The inspectors also commented that the hatches in the doors were very narrow, making nursing observation “dangerously difficult”.

7.3 Turning to the general condition of the healthcare centre, Sir David said:

“Much of the furniture in patients’ areas was broken or damaged and lavatories were very badly in need of descaling. Patients’ shower rooms were not tiled, had paint peeling off the walls and in one, the floor sloped away from the drain leading to a risk of flooding. Although cleanliness on the landings was generally satisfactory, standards of cleanliness were low in patients’ rooms, in waiting rooms and in interview rooms. In several rooms awaiting the admission of new patients, we found mattresses and pillows badly stained and torn. One pillow was heavily bloodstained ... the room call system ... was only working in part and the repeater boards were badly sited.”

He concluded that the “dirtiness and poor maintenance” he had found in the healthcare centre was “unacceptable”.

7.4 The Inspectorate was pleased to note that nurses had been trained in ‘jail-craft’, but also found that:

“... there had been no strategic assessment of the need for nurse training in terms of the skills, knowledge and experience required to provide an adequate range of interventions for patients with complex needs.”

7.5 Some nurses appeared to lack pride in their appearance as nurses and some chose to wear a uniform similar to that of healthcare officers, “since they felt this gave them higher status”. In addition, “Nursing documentation of in-patients was very poor. Nursing assessments had not been completed and notes were not always up to date.” Shortage of staff meant that nurses did not know where they would be working each day and it was “impossible to allocate staff according to their skills e.g. with more mental health nurses working with in-patients, and a named nurse system for in-patients became almost impossible.” The Chief Inspector went on:

“Despite all these problems patients told us that they appreciated what nursing staff did for them but wished nurses had more time to devote to direct contact with patients.”

7.6 Turning to the regime in healthcare, the Chief Inspector wrote:

“In-patients had a very restricted day. [Health Care Standards] require that patients are unlocked for at least 12 hours/day and in therapeutic activity for 6 hours/day. At Pentonville, patients were lucky if they were unlocked for 4 hours/day and 2 hours was more usual, especially at weekends. There were only two sessions/week provided by education

and not all patients were able to take part in these. The poverty of the regime for patients and the way in which the structure of the building prevented nurses from fulfilling their proper role, was particularly apparent with the eight-bedded ward. This was separate from other clinical areas and 'nursing' input was from a single nurse who sat behind a glass screen all day watching the patients but unable to talk to them or take any part in any therapeutic activity with them. Consequently most patients spent all their time lying inactive on their beds and the nurse's skills were wasted."

HM Chief Inspector of Prisons - 2002

7.8 The 2002 inspection team reported that the situation with regard to the general provision of healthcare had:

"... improved considerably, despite the fact that a new hospital was still two years away. These improvements included the provision of mental health care, the regime, managerial organisation and cleanliness."

7.9 In many areas of the prison, access to showers and change of underwear was "happening barely once a week". However, in healthcare, "Access to showers and clean clothes met our expectations" [that is, daily access to both]. The Inspectorate also reported "good regime activity" in the healthcare centre, "We were impressed by the professional approach to the delivery of programmes and the focus on meeting targets."

7.10 The Inspectorate noted that "the majority of healthcare recommendations made in our previous report had been achieved." They went on:

"Our expectation is that prisoners are cared for by a health service that assesses their need for healthcare and health promotion, which meets the needs identified and links them with the National Health Service. In a complex institution such as Pentonville, this was clearly an extremely demanding task. The prison had a very high turnover of prisoners, many of whom had significant needs due to mental health problems and poly-drug use. Some 85% claimed to be using substances on admission.

"There had been a great deal of progress in implementing the specific recommendations from our inspection in 1999. Of the 20 general recommendations applicable, 14 had been fully met, three had been partially met and three had not been met. The overall environment was considerably cleaner and in-patients had much greater access to activities as well as more time out of cell.

"... [The appointment] of a NHS senior health care manager as head of healthcare⁸⁵ ... had resulted in a great deal of work in reviewing staffing

⁸⁵ Mr Tony Madden took up post in December 2001.

levels, skill mix, the management and delivery of healthcare and developing action plans to improve the quality of care. Efforts to better manage demand ... were beginning to bear fruit ...

“The inclusion of both the head of health care and senior medical officer on the senior management team showed a positive commitment to reducing the isolation of health care and this has to be commended.”

7.11 Nevertheless, despite these improvements, Pentonville was still a ‘red’ prison under the Prison Service’s ‘traffic lights’ performance system.⁸⁶

2001 BoV report

7.12 The Board of Visitors noted that the budget for the coming year was less than the anticipated spend, so that “the prison continues to be tightly constrained by the resources available to it”. However, the Board had been advised “the year before last” that the building of the new healthcare centre “for which we have been pressing so long” had finally been approved. They hoped there would be no financial impediment in the succeeding two to three years to the building of this centre.

7.13 In the meantime:

“It is vitally important for the range and quality of healthcare provisions to be improved and extended, despite the inadequacy of the existing premises. Some progress has been made ... although we continue to be concerned about the shortage of staff in the healthcare centre.”

7.14 As noted in footnote 85, a healthcare manager (Mr Madden) had been seconded from the NHS for two years to manage the planned changes, and a senior clinical nurse had been in post since May 2001. Further recruitment of staff was underway. During the year a healthcare governor post had maintained responsibility for the custodial duties of the healthcare centre, and a principal officer had now been appointed to cover these responsibilities. Staffing continued to be problematic, “and is a major concern of the Board”. Agency nurses continued to be used to supplement the staff team.

7.15 The Board reported that the daycare centre had operated three days a week, offering sessions of art, counselling and education for prisoners from the wings who were at risk of self-harm, while an employment workshop had provided some activity for prisoners within the hospital setting. The Board said it continued “to be concerned about the impoverished regime for in-patients, an increase in suitable activities is needed together with more therapeutic opportunities.” They said, in summary, that they welcomed the progress made over the past year – “our concerns relate to staff shortages and the quality of care available.”

⁸⁶ This entailed reporting monthly via the Area Manager to the national Prisons Health Policy Unit/Task Force. See footnote 5.

What staff said

Physical environment

7.16 Ms Draper told the public hearing that staff at Pentonville were trying to deliver healthcare in difficult circumstances in a residential Victorian wing. She described it as far worse than what would have been found at Wormwood Scrubs, Wandsworth and even Holloway, which at least had dedicated healthcare areas.

7.17 Mr Attard said R wing was not designed as a healthcare centre. They had moved there “temporarily” some 10 years previously when the dedicated healthcare centre had been condemned because of asbestos. He said it was not ideal, especially considering the fact that about 80 per cent of patients had mental, as opposed to physical, health problems. The advantage of R wing, however, was that it was a small area and it was easy therefore for everyone to work together.

7.18 Various staff described the layout to us. They said R wing was a normal prison wing that consisted of five floors leading on from C wing. R1 and R2 held healthcare patients, R3 was for healthcare administration, R4 was for overflow and R5 for Vulnerable Prisoners. Prisoners with mental health problems were housed on R1 whilst those with physical health problems were located on R2. One officer suggested to us that R1 was more discipline/regime run, whereas R2 was more nurse led. Accommodation consisted of single cells and two five-bedded wards. An eight-bedded ward was subsequently introduced on the 2s.

7.19 We were told that the majority of patients had mental, rather than physical illnesses, ranging from alcohol and self-harm issues to psychosis. Many were awaiting sectioning under the Mental Health Act. There was a rapid turnover both of people coming in off the streets and those being moved from normal location (and back). The self-harmers were located on R1, and would be moved to R2 as the immediacy of the risk was judged to have reduced. (Those at risk of self-harm elsewhere in the prison were usually managed on normal location.)

7.20 The wing was quite dark, especially on the lowest landing which was below ground level and was effectively a basement. Apart from being given a few coats of paint, the wing had not been specially adapted in any way. However, staff said it was tidy, clean and bright, although noisy as it was adjacent to the Vulnerable Prisoners Unit. One Prison Service Nurse told us they tried to make the wing as healthcare based as possible and that “efforts to have a therapeutic environment were made”.

7.21 From a nursing point of view, observation was apparently quite good. The office (the ‘bubble’) was in the middle of the landing and had glass all round, making it easy for the manager to see out and to communicate.

7.22 We were told that the cells were identical to those on normal location. There was not much personalisation in them, and some of the cells on R1 (where the mentally ill were located) were “diabolical” according to one officer. The cells were small and contained a bed, table, chair, locker, sink and toilet. The doorways were narrow, meaning that access was difficult. Prisoners might have some books in their cells, and perhaps a radio if they had one, but there were no in-cell televisions at that time.

7.23 In his evidence, the forensic psychologist, Dr Robert Halsey, described conditions in the healthcare centre in 2001 as completely inadequate. He said it was not designed for people suffering from either physical or mental illness. It was no more than a wing that had been taken over for healthcare use – there was no specialist provision beyond some X-ray equipment and a dentistry chair. There was otherwise a complete lack of anything that would currently constitute a healthcare setting. He was particularly critical of the lack of any bespoke consultation facilities.

7.24 Mr Attard told us that the centre was dirty when he took over the day to day running, some 14 months before D’s attempted suicide (Mr Attard was acting healthcare manager until about January 2002). He had immediately set about cleaning it up physically and procedurally. They had improved the lighting and introduced a cleaning rota. They tried to keep the cells clean as well, but this was difficult in light of the particular population. No sooner were cells cleaned and tidied than prisoners had them looking as though they had not been cleaned for weeks.

7.25 Mr Davies said that, when he took over as Governor, healthcare was “disgraceful”. He said it was “filthy, absolutely filthy”, was rightly on ‘traffic light red’ and was the last to come off it (there had been about 12 prisons in the same situation).⁸⁷ Some 18 months after the 1999 inspection by Sir David Ramsbotham, it was still in a disgusting state. Even a cursory glance at the centre set alarms bells ringing. It was not clean and there was an air of despondency about the place. Staff were not engaging with prisoners. Mr Davies said there had been some improvements – but that this had been from an extraordinarily low base.⁸⁸

7.26 Mr Davies explained that work was moving ahead at this time to assimilate Prison Service healthcare within the NHS, a difficult task in any event. Given that Pentonville’s healthcare was failing, it was particularly

⁸⁷ The former Deputy Governor, Ms Kringle, said the healthcare centre was not “much worse” than other prisons – a lot were similarly placed.

⁸⁸ Mr Davies was asked at the hearing about the requirement to make improvements in order to secure funding for a new healthcare centre. Mr Davies agreed that this might seem odd on the face of it. However, Pentonville was not the only prison in this predicament. There was only a certain amount of money to go round and there was no massive capital spending at that time. Consequently, there was a need to compete for funds. In addition, simply putting more money into a failing centre would not of itself get results – it would simply produce more of the same at greater expense. Mr Davies acknowledged that he felt “a bit ill used”, but he saw the point.

challenging. Mr Davies said Islington Primary Care Trust was daunted by the prospect.

7.27 Nevertheless, Mr Davies judged that by December 2001 prisoners in the healthcare centre were treated as decently as elsewhere in the prison. He said the healthcare centre was not a place to dump difficult prisoners and that, after the introduction of community psychiatric nurses on the wings, they had been able to reduce dependency on the healthcare centre. By the beginning of 2002, therefore, numbers in the healthcare centre were significantly reduced and they had been able to turn wards into workshops.

Staffing

7.28 At the public hearing, Mr Hayward said five officers were deployed to R1, and two to R2, with one senior officer. He said the healthcare centre remained short of staff as it was difficult to recruit nurses and there was a “reasonable” sickness problem – he thought six staff might have been on long term sick at the time.

7.29 Mr Leane said staffing levels generally were not too bad, but agreed there was quite a high level of sickness absence. He thought it was probably higher than for the rest of the prison.

7.30 PSN Smith confirmed that healthcare was often short of staff at the time. He said they never had a full complement of staff and as a result were constantly pushed. Getting everything done was a “juggling act”.

7.31 Mr Attard advised that recruitment was ongoing at the end of 2001 as staff were constantly leaving and others joining.

7.32 At the hearing, Mr Davies said the prison was about 50 officers short in mid-2002. He said that this was the peak of the prison's difficulties with staffing, but that it was beginning to be a concern around December 2001. He estimated they were 30 staff short at that time. Mr Davies said it was not just Pentonville that experienced these problems, but all London prisons. He said the brunt of the shortages was borne on the main wings. The healthcare centre suffered from some shortages of clinical staff, but the officers there were good and committed and took little sick leave. There were therefore no big gaps in healthcare.

7.33 Ms Boateng said nurses had sufficient time for one-to-ones with patients, but there were issues around deployment of staff with RMNs being used as primary nurses. PSN Ansong also complained that, although he was an RMN, he could be deployed anywhere in the prison (not just the healthcare centre) and so his skills were inadequately utilised. (Conversely, general nurses were deployed to work with the mentally ill, “which was stupid”.) He said he would not know from one day to the next where he would be working and that there was a lack of continuity in patient care as a result.

7.34 However, Ms Draper told the hearing that she:

“... spent quite a long time at Pentonville during that particular period, [and at no time] did I ever get a feeling ... that [staff] didn't have an understanding and a knowledge of the prisoners that were in their care. And I think they all showed a high level of care and commitment to the prisoners that they were dealing with in very, very difficult circumstances.”

7.35 Former Senior Officer (now Principal Officer) Paul Parry endorsed this to some extent. He said staff in 2001 had a genuine concern for patient care. Nurses and officers at the time were good and genuine – though he added that there were some he would not employ now.

7.36 Dr Halsey's view was more mixed. He said there was a small number of very dedicated individuals in healthcare in 2001. They gave a genuine sense of attempting to provide the best clinical care possible in the circumstances – and to some extent they were successful with this. However, there were difficult working conditions, low staff morale, high staff turnover and much use was made of agency staff who did not carry keys. Many staff knew nothing about the people for whom they were supposed to be caring. It was difficult to provide the requisite level of care. In addition, some permanent staff found the environment difficult. There was a high sickness rate and low morale, but those who stayed did so because they could cope.

7.37 Mr Richards complained that he would come back after a couple of days off duty and find things had not been done. There were not enough officers and things were not organised ideally. He added that things had become worse during mid-2002, as people's attention turned elsewhere (that is, plans for the new healthcare centre). Everything had been improving around D's time but had declined afterwards.

7.38 Mr Davies described a “couldn't care less” culture amongst some nursing staff and a lack of care/moral courage. He said some had not even tried to do their job and that prisoners got in the way of them earning their money. He said he was ruthless in addressing this.

7.39 Mr Hayward confirmed that there were issues of quality with all the nursing staff – not just those from the agency. In addition, they were short on numbers. He said Mr Davies had been very supportive in making staffing changes to address the problem and reduce the reliance on agency nurses. Although the healthcare centre could be austere at times, relationships between staff and prisoners were very good notwithstanding the very rapid turnover. It was a busy environment and staff were constantly on the go, reacting to new situations.

7.40 Asked about the general quality of the nursing staff, PSN Ansong said he thought that the main reason he had left (in 2003) was that there was no in-service training. He was also critical of the use of agency staff as they came in with “no responsibility”. There was generally insufficient nursing staff.

Ms Kringle agreed that the staff (including the nurses) had typically worked in prison healthcare for many years and “probably needed more up to date training and information”.

7.41 Mr Attard told the hearing the introduction of Ms Kay George (an I grade nurse) was a “fantastic help”.⁸⁹ This was both in terms of providing a possible career path for nursing staff and also because she took the lead in clinical governance and driving up standards. Mr Attard added that there had been concerns about the morale of nursing staff at the time. He did not know if this had improved by December 2001.

Use of agency nurses

7.42 Gaps in the staffing complement during 2001 were filled by agency nurses. They were also engaged specifically to carry out one-to-one observations as these could not be accommodated within the normal staffing profile.

7.43 Dr Halsey said there were problems with particular aspects of nursing care – especially in relation to the use of agency staff. He told the hearing that agency staff had no keys or freedom of movement and did not know individual prisoners. These were not the characteristics required by the nursing function. A large part of the provision of nursing care revolved around the development of relationships and this took time. It took patients time to come to trust nurses and it was not easy for them to cope with new faces.

7.44 Mr Parry said agency staff tended not to be good quality and there was a total lack of interaction with prison staff. They could be caught dozing off, reading the paper or filling in their time sheets. However, he said it was not surprising if they sometimes switched off – it was not easy staring through a slit at a prisoner for hours on end. (Mr Parry acknowledged that some permanent staff might also have been guilty of similar misdemeanours from time to time.)

7.45 Mr Hayward said agency nurses were mostly used for 24-hour watches although they filled in elsewhere as necessary. However, some were not familiar with the prison and knew nothing about prison culture. In addition, none carried keys. Where possible, they therefore tended to be deployed to the treatment rooms rather than the landings.

7.46 Mr Attard told us there had been heavy reliance on agency nurses who were called in every time someone was put on constant watch. This could be up to as many as six at a time. He said regular nursing staff generally ended up working twice as hard when they were with agency staff because of the limits on what agency staff could do and because they did not carry keys.

7.47 He told the hearing there had been some concern that agency nursing staff were not familiar with the prison environment. There was also concern

⁸⁹ Ms George joined the staff in May 2001.

that many were mental health trained, when they did not need to be given the use to which they were actually put. In addition, the agency nurses did not input information about the prisoners into their care plans. Mr Attard said they therefore started to use healthcare assistants instead.

7.48 Mr Davies acknowledged that the prison's reliance on agency nurses had been a great weakness, albeit they were mostly used in relatively low-responsibility jobs. He said they were used primarily for observations. Mr Davies added that they were an unknown quantity and could not therefore be relied upon. However, some came back regularly and took greater responsibility.

7.49 He said agency nurses were provided with some rudimentary jailcraft. They were frequently aware of prison procedures (some worked elsewhere in the prison system) but did not always apply them. He said these staff were "not of the prison". They were also very expensive and much of the funding for healthcare was syphoned into funding agency nurses. The prison could be sent mental health nurses from the agency, but this was largely a matter of luck. They were often tired, as prison work constituted a second job. Mr Davies described Mr Attard as "particularly hot" on the question of agency nurses. He had introduced a procedure whereby only he, the Deputy Governor, or the governing Governor, could order them.

7.50 Those who gave evidence were unsure about the training received by agency nurses. The consensus appeared to be that they were simply briefed in relation to their particular duties for that shift. They did not receive any prison induction and had no training in jailcraft.

7.51 Not everyone viewed agency nurses so negatively. Some made the point that the same individuals came regularly and so knew the patients and the environment well. To all intents and purposes they were like permanent staff.

Regime

7.52 It was difficult to gain a clear idea of the regime in operation at the end of 2001 as the accounts given by staff varied.

7.53 Mr Leane told the public hearing that staff had tried to get prisoners out of their cells as much as possible. The degree to which they were able to do so differed from day to day, depending on what was going on in the prison. On a good day, prisoners would be out of their cells for two hours in the morning and then, if it was their turn for exercise, might be out for a further one to two hours. On a bad day, prisoners would be out of their cells for just one hour in the morning. They could attend classes and could go to the gym once a week.

7.54 Other accounts were rather more positive. Ms Boateng told us that patients were out of their cells for much of the day in 2001 – usually from about 9:00 am or 10:00 am onwards. Mr Richards told the hearing that,

towards the end of 2001, prisoners spent virtually the whole day on association. At the time D was there, Mr Richards and other discipline officers had been trying to get a regime going. They tried to get prisoners into a regular routine of getting up, washing, shaving, and then out of their cells doing something by 8:30 am. The officers had set up a workshop and about 10 prisoners worked there. Prisoners remained unlocked until about 12:30 pm, when they were locked up for about an hour before being unlocked again until tea-time which was at about 4:30 pm. Mr Richards said up to six hours a day out of cell was a regular occurrence. However, this would not happen if it was not operationally safe to do so – if there were insufficient staff, for example. On some days there was hardly any association. On those occasions, staff would try to let prisoners out in stages taking half a landing at a time. Referring to an earlier interview, Mr Richards said he did not now recall a period of four months during 2000 when prisoners had no association.

7.55 He also said he did not recall a 23-hour lock down over the Christmas period. A weekend complement would have been on duty over the holiday period.⁹⁰ There would have been no difference to staffing levels in the healthcare centre – except that there would have been no clinics so they would have been minus the two staff normally deployed to the clinic. He added that he would be surprised if they had had a 23-hour lock down but, even if there had been, staff would have got one or two prisoners out at a time to play pool or whatever.

7.56 Although Mr Hayward corroborated Mr Richards' account of the daily regime, he suggested to the hearing that this would have represented a 'good day'. He said there was limited association due to gaps in the detail as well as absenteeism. Nursing staff sometimes did not feel safe unlocking prisoners. Mr Hayward explained that the prison regime comprised some non-flexible, some part-flexible and some flexible elements in the rest of the prison. However, in healthcare all elements were non-flexible – for example, they had to run treatment rooms regardless. If there were insufficient staff, R1 could remain locked down for an entire day. However, staff would try to get prisoners out two at a time to clean etc. Mr Hayward thought there was quite a lot of association in healthcare in December 2001. He said staff were not supposed to run association with fewer than four staff, but in fact they did so even with two. This did not happen often in December 2001 because they now had discipline officers. He said that, on good days, prisoners would have seven to eight hours out of their cells. They were at the mercy of sickness absence, but the main aim was to get prisoners out of their cells as soon as possible. He said he had not heard about a 23 hour lock up over the Christmas period, but would have been surprised if there had been. At the least, they would have had to have given prisoners one hour's exercise.

7.57 Mr Hayward said at interview that, although the prisoners were out of their cells most of the day, there was little to tax their minds. (Another officer

⁹⁰ At interview, the former Governor, Mr Davies, said it was a fallacy to suppose that prisons were short staffed at Christmas. He said the complement would be appropriate to whatever day of the week it was. There was therefore always plenty of staff. Regimes were sometimes trimmed, but they would be properly staffed for the needs of the prison.

described prisoners' activity as "not very purposeful".) An attempt had therefore been made to set up a workshop to keep them gainfully employed. Mr Hayward said that staff interacted all the time with prisoners when they were out of their cells.

7.58 Mr Attard explained that they had introduced some light work for patients (assembling medical records), but there were days when the workshop could not be opened because of staffing constraints. He described the regime as generally fairly good, with most prisoners out of their cells for long periods.

7.59 Mr Davies told us they had got rid of the dormitories and turned one into a daycare centre. However, its delivery was rather fragile. The prison also employed an art therapist. This cheered people up. Some work was also provided, putting files together. It was rudimentary, but it was still work. Prisoners also had PE. He confirmed that Mr Attard was steadily building a regime.

7.60 Nevertheless, because the two disciplines were by this time working together, the shortage of nurses impacted on regime delivery. Mr Davies commented that the shortage of anyone who interfaced with prisoners would affect the regime. He said this created a need to switch round which tasks were done. A certain number of staff was required to supervise prisoners whilst they were out of their cells. This number would include nurses. If they were short-staffed, it could not be done.

7.61 (I infer from Nurse Chikuku's comments about D covering his cell flap that he was in his cell the whole of the morning of 27 December. Certainly, he was locked up when Mr Leane returned to the wing at 2.00 pm and he was returned to his cell after the phonecall because there was no association that afternoon. This suggests that there was little time out of cell on that particular day. It may be significant, however, that it was a Thursday when the prison was locked up in the afternoon for staff training.)

Incidence of self-harm

7.62 I tried to obtain an idea of the extent to which self-harm was a problem in the healthcare centre during late 2001. Accounts varied and it was clear that there were peaks and troughs. Some witnesses said incidents of self-harm by patients already on the healthcare centre were rare (although prisoners who had self-harmed on the wings were brought to the healthcare centre).

7.63 Ms Kringle thought that incidents of self-harm were not a daily occurrence and those that occurred were not necessarily very serious or attempted suicides. She estimated there might have been about 20 incidents a month. There was a lot of self-harm but very few suicide attempts. The prison collected statistics to try and identify the most vulnerable types of prisoner and the most vulnerable times.

7.64 Conversely, PSN Ansong said there was “a lot” of self-harm. He said that it was an almost daily occurrence “especially with the drug addicts,” and considered it a matter of luck that people did not die.

7.65 A couple of staff made the point that, given the level of mental illness on the wing, the risk of self-harm was ever-present. Estimates ranged from about 20 per cent to 35 per cent at risk at any one time.

7.66 Asked whether self-harm had become routine, Mr Richards said only insofar as opening forms etc was concerned. Each prisoner was still an individual. He said some prisoners self-harmed in order to obtain more medication or a cell change or to avoid a transfer to another prison. However, all self-harm was treated seriously. He said he “tiered” seriousness in his own mind, but reacted whatever his own views were. It was necessary to know what exactly was going on to pass on appropriate information at handover. He would therefore have made sure he found out by speaking to the prisoner and spending some time with them.

7.67 Mr Leane told the public hearing he thought that F2052SHs were raised more often towards the end of his service (early 2002), but he had no idea how many would have been open in the healthcare centre. During interview, he said prisoners were no different from what they had always been; staff were more nervous and wanted to cover their backs in case something happened.

Communication

Documents in use

7.68 Several documents were in use in the healthcare centre for communicating information about patients and incidents:

- A wing observation book was used to convey general information that staff would need to know in order to ensure the safe and secure running of the wing. It included information about individuals but focussed on behaviour rather than clinical matters. It was introduced from the normal wings by discipline officers and was used by them and some nursing staff and healthcare officers.
- The IMR was used to record all clinical information, including notes of consultations, diagnoses, medication and instructions to staff. These were principally used by doctors, although others had access to them and could make entries if there was information of which they thought doctors should be aware.
- Nursing plans were drawn up by nurses and described the nursing care to be given to individual patients. They appear to have been used and referred to solely by nurses.
- The F2052SH was a document that could be opened by any member of staff in respect of an individual prisoner who was considered to be at risk

of self-harm.⁹¹ It included the reasons for opening the form and the initial observations of the unit manager. It also contained a brief assessment of the risk by healthcare staff, and records of case reviews and action to be taken (the support plan). Finally, there was a section for recording any significant events or other observations about the patient. Any member of staff could (and should) have had access to the document and been able to make entries.

7.69 The effect of this number of documents for recording and communicating information was explored in some detail at the public hearing. The picture that emerged was that some staff would routinely refer to some documents but not to others, and that different people used the various documents for different things. While some information was replicated between documents, some was not. As Mr Morton summarised in his closing statement, this meant:

- Mr Leane and Nurse Chikuku were unaware that razors and a noose had been found in D's cell on the morning of 27 December. Mr Richards, who made the discovery did not record the location;
- there were no entries in the wing observation book relating to D between 15 and 27 December notwithstanding that on 16 December he had a period of head banging, on 19 December he was throwing things in his cell, and on 25 December he said that he was going to die that night but subsequently told staff he was okay;
- there was no entry in the wing observation book relating to 4 December when D was found to be ripping dressings from his arms and saying that he did not want to live, or for 6 December when he was seen to rip up a sheet and attempt to conceal it;
- some matters were recorded in the wing observation book and some in the F2052SH and some in both;
- the IMR was not (no doubt for good reason) available for inspection by wing staff.

What sort of information was recorded where was not always consistent. Hence, the only way to obtain a full picture of a patient was to read all the documents. Those reading only one or two would only get partial information.

7.70 Mr Richards confirmed at the hearing that he would have expected an episode of head banging by D, and his saying he was missing his daughter, to have been recorded in the observation book. Likewise D apparently having said he would die that night (on 25 December). However, he thought these incidents were more appropriate for the F2052SH as the observation book was intended more as a summary of events.

7.71 He said he would expect most entries to be made in both the F2052SH and the observation book, but if staff were busy this might not happen. In addition, there were some items that were appropriate for one document but

⁹¹ Dr Ranaweera estimated that about 20 per cent of prisoners would be on open F2052SHs.

not for the other. It would be possible to spend the whole day writing if everything was recorded everywhere.

7.72 Mr Richards explained that the observation book was kept in the office on the 1s and was always open. Anyone could make entries, the purpose of which was to make other staff aware of significant events. It was not something he looked at every 20 minutes, because he would know for himself what was happening on the wing. However, he would tend to read the book when making entries himself.

7.73 Mr Richards agreed that the F2052SH was a valuable document. He said the case reviews were documented so he could read to see how a prisoner was doing. The document was a good tool because it was individualised. He said the forms were in constant use and he could make entries and see what others had written. In that way, he could better understand why a prisoner was behaving as he did. He said he would refer to the document continually – roughly every couple of hours.

7.74 Mr Leane said discipline officers did not have access to the F2052SH support plan (although they did have access to the rest of the F2052SH) or the IMR. They had access to the prisoner's general record, which contained basic information but not any reference to self-harm.

Record keeping/management

7.75 In her report, Ms Draper found medical documentation systems "chaotic and inefficient, frequently leading to the loss of important documentation". In particular, Ms Draper noted that the 15-minute watch sheet for D for 27 December was missing and could "not be found despite extensive searches" by the prison.

7.76 At the hearing, she clarified that it was not fair to say that staff at Pentonville had no control over documentation. There had been difficulties managing medical information and these had been identified and acknowledged and action was being taken to rectify them.

7.77 Mr Hayward thought they were quite good at paper-keeping, although he acknowledged that this was not always the case. Where it was not, he thought it was down to individual error rather than systemic problems.

7.78 However, Mr Attard told us there were difficulties over accessibility and storage of medical records. He said it could be difficult to get the IMR and the patient before the doctor at the same time. As a result, doctors quite often opened temporary IMRs. Mr Attard said the IMR room was poorly managed and no single person was responsible for it. Staff would take IMRs out and not leave a record that they had done so. The same difficulty applied to pharmacist records, and doctors sometimes had no way of knowing what medication a patient was on. Sheer throughput of prisoners caused difficulties, with records being packed up for court appearances and then going astray.

7.79 Dr Halsey confirmed that the medical records often went missing. He said a new IMR was opened every time a prisoner came into the prison – regardless of whether he had been there before. Officers would know the prisoner, and medical records would exist, but a new IMR was opened nonetheless. More valuable information could often be obtained from officers than from the medical record. This was even more of an issue for prescribing doctors since they would know nothing of a patient's prescription history. He added that the high turnover of patients overwhelmed the paper-based system.

7.80 Dr Halsey said he generally saw between five and seven patients in a session and it was unusual for all the IMRs to be available. However, it was less common for in-patient records to be missing. There were physically not many places where an IMR could go – there was only one office where records were kept.

7.81 Dr Yisa said records and record keeping were a problem throughout the Prison Service. The position with regard to medical records was a complete nonsense. They were provided with just one records office and it was a problem managing/keeping track of documents.

Handovers

7.82 With the single exception of PSN Ansong, all witnesses said that handovers were a regular part of the routine and that they were effective and appropriate.

7.83 Mr Hayward told the hearing that, before Mr Attard's arrival, handovers were sporadic and information was not being communicated. They were therefore formalised and held in the mornings, the afternoons (if necessary), and for night staff coming on duty. Whoever was in charge of the landing ran them, and they were attended by all discipline and nursing staff (and, to begin with, by the duty doctor too). Agency nurses would attend unless they were on constant observations, in which case they were briefed subsequently. They would go through individual cases and note any F2052SHs and the support plans. They would also mention any noteworthy incidents reported in the observation book. In the early days, there had been a single handover for both landings. This was subsequently changed to two separate handovers. Mr Hayward judged the standard of communication to be good.

7.84 Mr Richards said they would go through the prisoners individually and learn about any occurrences during the night. He said all relevant documents were to hand for the handovers – the IMRs, nursing plans, observation books – and were referred to as necessary. The handover would last about half an hour and duties would also be allocated during this time. They did not discuss everyone at length, only the basic details. (Mr Richards reported that, because of the shortage of staff, there was never much other opportunity to discuss things with colleagues.)

7.85 Mr Leane said that, as a rule, he knew what he was supposed to be doing on a daily basis and everything felt pretty much under control. He told the public hearing that staff would learn from morning briefings why prisoners were on open F2052SHs. Briefings were held every time there was a staff changeover. He “assumed” they would have looked through any F2052SHs and looked at the observation book and the board. He said the last person on duty did the handover for the next one on, drawing on the observation book. How long was spent on each prisoner depended on the prisoner – it could be two minutes or ten.

7.86 Nurse Chikuku said she started her shift at the same time as the officers. There was a general handover for everyone with officers present. The nurse in charge led them. Staff were simply told how prisoners had been and if anything had happened during the previous shift. It was “pretty basic information”.

Patient care

7.87 Dr Ranaweera explained that all new prisoners were assessed by nurses at reception. If any problems were identified at that stage, the doctor would see the patient straightaway (otherwise, the doctor would see them later in the day). The patient was then allocated to the particular doctor on duty that day.

7.88 Dr Ranaweera said each new patient was given a care plan on reception and the nurse would then draw up a nursing plan to implement it. During initial assessment, doctors would take a full history from the patient, including physical and mental health and their social/home circumstances. The doctor would apply to the local GP or hospital for further medical information and to confirm any medications prescribed. Reference would be made to IMRs from a previous prison where possible, but it was not routine to request them (as opposed to a patient’s past mental health history). Otherwise, doctors were dependent on what the prisoner told them. There would be a full management plan in the IMR following ‘clerking’ and the nursing plan would be updated accordingly.

7.89 Any follow-up care would be provided by the doctor who was on duty when the prisoner first arrived unless he/she was not in the prison for any reason. This provided consistency of care. However, there was always a duty doctor available during the daytime, and at other times there was a doctor on call.

7.90 Dr Ranaweera told the hearing that, in addition to the shift handovers, doctors would discuss the patient’s management plan with whomever was in charge of the landing. That person would actually see the care plan, although doctors did not see the nursing plans. The nurse on duty at the time was responsible for drawing up and implementing the nursing plan. Dr Ranaweera

was not sure if prisoners had their own 'key nurse' and was not sure how the work was divided up.⁹² It was not the doctors' responsibility.

7.91 Dr Ranaweera told the hearing that either a healthcare officer or a nurse would be in charge of the landing. Ms Kay George was the nursing manager but was not usually in the healthcare centre. There was no formal link between the nurses and the doctors – it all fell to day to day communication.

Healthcare in 2007

7.92 In his statement about healthcare at Pentonville in 2007, Mr Jonathan Warren, the present-day healthcare manager, said he took up post in January 2006. He advised that he had managed the move to an electronic patient record and introduced a primary mental healthcare service for prisoners suffering mild to moderate anxiety and depression. He had also ensured that all staff received appropriate training.

7.93 Mr Warren described the new healthcare centre as a "purpose built, two-storey centre" offering a "clean, safe and bright environment". The staffing complement was a mixture of nurses and healthcare officers, many of whom had had specific training in mental health. There was a daycare centre for prisoners deemed vulnerable or suffering from mild to moderate mental health problems, and a range of interventions from art and exercise to Cognitive Behavioural Therapy for anxiety and depression. The prison also had the services of two counsellors who worked one day a week.

7.94 Handovers at the end of each shift ensured key information was exchanged. It was easy for staff to speak to one another on the ward to alert them of any special concerns about a particular prisoner.

7.95 Mr Warren advised that the healthcare centre used about four or five agency nursing staff each week. These had "in the main" worked at the prison for at least six months. All had up to date professional training, and emergency procedures were "always explained" to them. Agency staff would "have undergone self-harm and suicide prevention awareness training as part of their basic nursing training," and Pentonville did not provide specific self-harm refresher training. Mr Warren added that all agency staff had supervised training on the job. They could sometimes be used for constant observations but this was rare because prisoners were not often placed on constant observations as it could be intrusive and distressing for them.

7.96 I visited the new healthcare centre at the outset of my investigation. It is an extremely impressive facility (although I noted that quantities of files had

⁹² Mr Hayward said at the hearing that a named nurse procedure had been in place by the end of 2001, with a primary or secondary nurse being allocated to each patient. Their identity would be recorded on the roll board but not in the F2052SH. Mr Hayward could not recall whether D had a named nurse. (Ms Chikuku did not recall there being any key workers.)

apparently been left dumped in R wing⁹³). There is no doubt in my mind that healthcare in 2008 is very different to what existed in 2001.

Consideration

7.97 Taking together the reports from HM Chief Inspector of Prisons and the accounts of staff, there seems little doubt that R wing fell physically far short of what might reasonably be expected of any healthcare centre. It was unprepossessing and had little natural light. It could also be very noisy. Visibility into cells was poor and the cells themselves very basic. Those prisoners who were mentally ill and/or at risk of self-harm were located on the bottom landing, which was the darkest of all. The cells can only be described as grim.

7.98 However, from the various accounts we heard, it does seem as though the wing was at least clean by the end of 2001. In addition, the landings were fairly small and there were good sight lines.

7.99 Accounts of the number of staff on the wings at any given time are sketchy, but the consensus appears to be that there were sufficient staff, albeit they were not deployed in a way that best utilised their skills or facilitated consistency of care to the patient. Quality too appears to have been mixed. As in any organisation, some staff were good and caring and others were not.

7.100 Referring generally to the care provided to D, Mr Eadie said in his closing statement that:

“... there can be no doubt that all those who were working in the healthcare centre, whether discipline officers or healthcare staff, were doing the best that they could in a difficult physical environment ... all those who have given evidence plainly were focussed on the needs of those within their care.”

7.101 However, Ms Stern commented in her closing statement that:

“There were also problems in reliance upon agency nursing. As pointed out by Dr Halsey, caring for those with psychiatric vulnerability requires a relationship which was lacking with agency nurses ... This was a real, and problematic, aspect of the difficulties ... on 27 December 2001.”

7.102 I think that notwithstanding the efforts of many staff, there probably were weaknesses in staffing at Pentonville at the time. Certainly, deployment practices and the use of agency staff might have made it difficult for D to strike up a rapport, and meant the staff best able to address his needs were not always located on R1. However, healthcare provision is completely

⁹³ D's IMR might have been amongst them but it would have been a gargantuan task to sort through them all.

differently organised now, and I see no merit in making any recommendations on this score.

7.103 Insofar as agency staff are still used, however:

I recommend that all agency nurses at Pentonville are given a full induction into prison procedures and practices, particularly with regard to suicide prevention.

I also recommend that the Governor considers whether some agency nurses should be key trained.

7.104 I turn now to the somewhat hit and miss regime in operation in Pentonville at the time. In attempting to explain why the highest incidence of suicide occurred in local prisons where prisoners were locked up for hours on end, 'Suicide is Everyone's Concern' had pointed out the need for more activity. A guide to Prison Service policies and procedures, 'Caring for the Suicidal in Custody', said:

"Good relationships are more likely to flourish where prisoners live in decent physical conditions and there is a full programme of positive activities. This will ease the boredom, tension and frustration, improve the quality of life and create a better atmosphere between staff and prisoners. Of particular value are developments in regimes and in health promotion which offer opportunities for the more vulnerable to take part in activities, build self-esteem and gain confidence in their ability to take responsibility for their lives and cope with stress."

7.105 It is clear from the evidence that there would have been some (possibly many) days on which D had a considerable amount of time out of his cell. Even so, there appears to have been little to occupy him when he was out and even fewer "purposeful activities" (although work on enhancing the regime was in hand at the time). On other days, it seems likely that he would have spent many hours locked behind his door. Together, this can only have had a detrimental effect on his state of mind.

7.106 There were undoubtedly issues about communication (caused partly by the sheer number of documents used for the purpose). This meant that some events were recorded in one document whilst others were recorded elsewhere. I sensed a lack of clarity around what information should most appropriately be recorded where. In some cases, information was replicated between documents (which, whilst necessary in the circumstances, was inevitably burdensome for staff), but generally it seems that it would have taken considerable effort to build up a complete picture of a particular prisoner.

7.107 I am also concerned about the 'chaotic' record keeping. It cannot be appropriate that doctors had to make decisions without sight of relevant information – especially with regard to prescriptions. I appreciate that efforts

were made to get to grips with the situation, but the fact that D's IMR has been completely lost gives little comfort.

7.108 I cannot of course say whether either of these points impacted on D's care, but manifestly it is possible that they did. However, I found no evidence that the levels of self-harm in the prison generally and in healthcare in particular had resulted in a sense of complacency amongst staff.

7.109 Ms Stern considered the handovers inadequate. She said that:

"... only the immediate past was considered, and even that was cursory. This did not enable continuity of care having regard to an overall risk assessment."

7.110 Mr Eadie acknowledged that handovers might not have been ideal, but said they did at least occur between each shift. He suggested that any inadequacy was compensated by the fact that all staff had access to the F2052SH and the observation book, because the allocated doctors had in-depth knowledge of the prisoner, and because there were daily ward rounds and twice weekly case conferences. There is clearly something in Mr Eadie's argument. However, I am not persuaded that these compensating factors were sufficient – especially with regard to those staff who had no time (including, for example, Nurse Chikuku) or no inclination to read what was available.

7.111 Turning to patient care, Ms Stern commented that ward rounds took place without the prisoner being present. In addition:

"The fact that the lack of visiting psychiatric involvement in D's care was not identified casts doubt upon the effectiveness of ward rounds, and as to the operation of the system as described in the evidence. It is also clear from Carole Draper's report that, despite the system as described, no probation officer, social worker, or chaplain was ever involved in D's care or case management (despite him having been referred to the chaplain, Samaritans and Listeners on 4 December 2001 ...) Nor did they involve discipline staff, who appear to have been most involved in the care of D."⁹⁴

She also considered that the allocated doctor system failed in D's case.

7.112 It is notable that, although Dr Ranaweera was D's allocated doctor, Dr Yisa appears to have figured more largely in his care. This might be because of the particular complexity of D's case and the challenges that he posed. However, it may simply be a reflection of the fact that Dr Yisa responded to the emergency situations that were recorded in the observation book. The IMR might have shown a high level of input by Dr Ranaweera (she gave

⁹⁴ I am not sure on what basis Ms Stern makes her assessment that it was discipline staff who were most involved with D. A number of entries in the observation book were made by nursing staff. In the absence of other contemporary documentation, I do not see that it was possible to say which 'side' had most to do with D.

evidence that she reviewed patients daily and took part in the twice weekly ward round). The fact that a doctor did not see D between 18 and 27 December 2001 is, however, a cause for concern.⁹⁵

7.113 As for the ward rounds more generally, I have to agree that they apparently failed to identify shortcomings in the implementation of D's care or support plans. In addition, although they were apparently held twice weekly, there was no record of any in D's IMR for the period referred to above (although Ms Draper referred to a case conference being held on D in his absence at court). It may have been, of course, that his IMR was not available and any continuation sheets had not been attached to his IMR prior to 27 December.⁹⁶ But this of itself is hardly auspicious.

Equivalence

7.114 By way of background to his review, Professor Rogers noted that in 1997 the Health Advisory Committee for the Prison Service reinforced the principle of equivalence of care within and outside prisons. He said they had stated unequivocally that prisoners should be entitled to expect the same standard of healthcare as that provided in the community, and have similar access to NHS beds. Therefore, at the time of the period in question, "there was, in my opinion, a clear understanding within the Prison Service that all prisoners should expect the same standards of care as that provided within the NHS." His conclusions took account of this aspiration which, he said, was clearly understood within the Prison Service at the time of D's imprisonment at Pentonville.

7.115 Amongst other things, Professor Rogers said there should have been a key nurse who was responsible for D's care 24 hours a day. This would be a single person who would write the care plan, and give a clear indication of what needed to be done and the triggers for self-harm.

7.116 Mr Davies was asked at the hearing if there was equivalence of provision between Pentonville's healthcare and the National Health Service. He suggested that, in terms of mental health care, detoxification and some clinical care, the prison's healthcare centre surpassed what would have been available outside and this had been achieved on a shoe-string budget. Dr Cumming commented that 2001 was early on in a process aimed at establishing equivalence of care – "Thus at the time of D, changes were underfoot but not necessarily complete."

7.117 Dr Cumming said he was not aware of any established protocols for managing nursing. Key workers were ideal, but aspirational. However, there should have been a care plan. Dr Cumming said equivalence was not a

⁹⁵ Dr Ranaweera has explained that she was on leave between 25 December 2001 and 2 January 2002. She did not work weekends, so would not have been in the prison on 22 and 23 December.

⁹⁶ Dr Ranaweera noted that D went to court on 20 December, and that it was routine practice for the IMR to accompany a prisoner when he attended court.

realistic prospect because of the different situation and different culture that obtained in the Prison Service as opposed to the NHS.

7.118 I agree with Dr Cumming that 2001 was too early to have expected the Prison Service to have achieved its aspiration. I have not considered the matter at length but it seems to me that in any case 'equivalence' is not a synonym for 'the same'. What it means is that, given the particular prison context and the constraints and challenges that are an ineluctable feature of prison life, clinical care and outcomes should broadly reflect the experience of those in the community. It does not mean that the Prison Service must replicate NHS processes.

PART VIII - DISCIPLINE STAFF IN A HEALTHCARE SETTING

The perceived need

8.1 Mr Davies told us that, when he arrived at Pentonville, very few non-healthcare staff worked in R wing. Whilst nursing staff were good at medical/healthcare work, their institutional skills were not so well developed – issues such as keeping the place and the people clean were neglected. Mr Davies said he wanted a firm hand on the way the healthcare centre was run and took the view that prison discipline officers were needed for this side of things.⁹⁷ He therefore told the senior medical officer, Dr Yisa, whom he described as a deeply concerned and committed man, that he did not have the requisite managerial skills and that Mr Attard (then an acting principal officer) would take over the day to day management of the centre. (He in turn was overseen by Mr Monaghan, residential governor.)

8.2 Mr Davies said they had done a lot to address the management of those at risk. CPNs had helped, but much revolved around the fact of depression and that depressed people could not think of anything positive about themselves. If you improved decency, control, interest, choice, cleanliness, you were actively supporting optimism. Cleaning, good food, people properly dressed –these were all basic measures that helped. In addition, the discipline staff talked to the prisoners more than the healthcare staff.

8.3 Mr Attard and Healthcare Senior Officer Peter Hayward had set about deep cleaning the wing. Mr Davies said there was a huge improvement in terms of cleanliness within days. In addition, issues such as prisoners walking about with no shoes were addressed and the hot-plate was properly administered. The cells of the mentally ill patients were cleaned twice per day. By about October 2000, they were beginning to know what they were doing. Mr Davies said they made a huge advance but then tended to stall a bit. Nevertheless, by the end of 2001, things were looking quite reasonable.

8.4 Mr Attard said he had wanted to introduce discipline officers into healthcare because of the number of alarm bells that were going off there – sometimes three a day – as compared with the rest of the prison. He said some nurses were not good at managing prisoners. Mr Attard said he had hand-picked four discipline officers to work in the healthcare centre. He chose them for their inter-personal skills and their firmness in their approach to prisoners. He said the officers were outstanding at engaging with the prisoners. (Nursing staff saw their duties as being purely clinical and would not unlock prisoners etc.) As a result, the number of alarms reduced to one or two per month. He confirmed that the introduction of discipline officers increased the overall staff numbers in healthcare (rather than replacing nurses).

⁹⁷ Mr Davies said they had found an unexpected bonus of tightly regulating the use of agency nurses was that control of the budget gave them control of staffing. By this means, 11 discipline officers for healthcare were paid for.

8.5 At the public hearing, Mr Hayward said the introduction of discipline officers provided stability. They had a calming influence. They also filled gaps in the detail. He judged that the introduction of discipline officers provided the quality that was lacking. They knew how to deal appropriately with patients, whereas nursing staff tended to back off from the more problematic prisoners.

8.6 Mr Hayward explained that the centre had not been out of control, but staff were not able to do all they wanted (for example, offer exercise) and the nurses were not keen. Discipline officers were brought in to release nurses to get on with their jobs and improve the regime.

8.7 Mr Leane told us that prisoners got away with much more with the nursing staff than with the discipline staff. Nurses tended not to get involved where anyone “kicked off” or where there were other discipline problems. Some of them would have been physically intimidated – they were often much smaller than the prisoners – and tended to stay out of things.

8.8 PSN Smith reported that nursing and discipline staff worked well together, with discipline staff tending to be deployed to the mentally ill prisoners as their behaviour was more challenging.

Relationship between nursing and discipline staff

8.9 Mr Davies said there was some difficulty with Mr Attard taking over management of the healthcare centre to begin with, because historically prisons had been run by a triumvirate of the Governor, chaplain and senior medical officer. As a result, the SMO was not used to answering to anyone other than the Governor. However, he said Dr Yisa eventually accepted Mr Attard as he saw that his intentions were good and he was getting results. Mr Davies noted that, whereas in the early days there had been a clear demarcation of roles, this had died away by the end of 2001. There were still some staff who gave concern, but the ethos had changed.

8.10 Mr Leane confirmed that there was a culture of “them and us” between nursing and discipline staff. He said the former resented the latter as they saw it as an encroachment on their territory. He said the two disciplines took a different approach – nursing staff might be more likely, for example, to use the prisoner’s first name.

8.11 Mr Richards said that, once discipline staff arrived, nurses refused to undertake certain duties. He said there were uneasy feelings, but that he dealt with nurses all the time and interacted fully with them.

8.12 Dr Halsey thought the relationship between nursing and discipline staff at the prison was reasonably good, as they were between nurses and doctors. There was a lot of stress and the working conditions were very difficult, but people treated each other with respect and relationships were functional.

8.13 Dr Yisa was less positive about the changes. He said everything had gone to pieces after Mr Attard was posted to the healthcare centre. Things were not done properly any more and that, as a consequence, care of patients was not as good in 2001 as it had been in 1999. Before 2001, there was a nurse for every three patients, hence numbers were quite high, rather than just two or three nurses with the rest of the complement made up of discipline officers. Dr Yisa added that the changes in management, staffing levels, skills mix etc made life very difficult. Dr Yisa said that they did their best and staff did not give up on caring for their patients. He agreed with the principle of purposeful activity for patients/prisoners, but this should have been introduced in conjunction with the old processes and standards.

Training for discipline staff⁹⁸

8.14 Mr Attard told the hearing that he did not come from a medical background. He said this was unusual in a head of healthcare but not unique. He explained that his role was managerial not clinical. There had been a clinical principal officer in post when he first transferred to the healthcare centre, and the senior medical officer was in the lead on clinical issues. When he had joined the healthcare centre, the decision had already been taken to bring in an NHS manager – a nurse consultant. He arrived at about the time the clinical principal officer left (December 2001) and had stayed for about six months.

8.15 Mr Davies said the discipline staff were selected for their institutional performance, their reliability and their sense of duty. They were not given additional training for the role, but were brought in to introduce some order onto the centre. The nurses were clinically adept – they were good nurses – but they were institutionally inept. It was a different skill.

8.16 Mr Hayward said discipline staff had no formal training in dealing with the mentally ill. The original intention had been for healthcare officers to become NVQ qualified, but bespoke training in this respect had ceased in 1992. However, they brought other valuable skills to bear. At the hearing, he said training was provided for discipline officers during an afternoon once a week. He led this with the head of nursing, Ms Kay George, who covered matters such as respiratory diseases, diabetes etc – that is, general nursing matters. This gave discipline officers a feel for what was going on and helped to embed them into the healthcare team.

8.17 Mr Richards said that he received trauma training on going to the healthcare centre (he thought he also received first aid training but could not remember it). He said he also undertook a healthcare assistant's course at

⁹⁸ Discipline staff in the healthcare centre were distinct from healthcare officers who in effective straddled the clinical and discipline roles. The latter came from either discipline and were then cross-trained. Those coming from discipline received about three months training in clinical matters. This compared with three years for nurses. In some respects, however, Mr Hayward thought healthcare officers actually did more than nurses. There was some controversy over this, which he suggested may have resulted in part from professional snobbery.

the Royal Free Hospital. This took place on one day a week over the course of ten weeks between about March and Summer 2001 and covered basic healthcare functions. It also enabled him to recognise schizophrenia and understand the associated behaviour.

8.18 In contrast, Mr Leane told the public hearing that he could not recall any particular training given to discipline staff allocated to work in the healthcare centre.

Management lines

8.19 Dr Yisa said that, before 2001, named nurses had been managed by the senior nurse. He confirmed that Ms George was in post by December 2001. Her role was originally to lead and supervise nurses and oversee care plans, but Dr Yisa “could not say” what her role might have been after Mr Attard’s arrival. He said nurses reported to Messrs Attard and Monaghan. All the old arrangements about governance, care plans etc now fell to Mr Attard who came exclusively from the discipline side. He had no training or experience in healthcare.

8.20 Dr Yisa said he had no responsibility himself for nurses, but this would not have mattered if he had been able to maintain consultation lines. However, there were not appropriate or adequate lines of communication with senior nursing staff.

8.21 Mr Davies said the chain of command on the discipline staff was that officers reported to Senior Officer Hayward, who reported to Mr Attard, who reported to Mr Monaghan, who reported to the Governor. There was no equivalent structure for nurses and no head of nursing at that time.⁹⁹

Decision making

Level of observation

8.22 In her report, Ms Draper observed that there appeared to be “considerable uncertainty” as to who had the authority to place a prisoner on a one-to-one watch. She said she could not recall seeing any documentation that dealt with this point. She noted that any medical officer “obviously has the authority”, but noted that one might not be around when a decision was needed. She said there was a need for clarification about the level of authority required.

8.23 Asked if controlling the number of agency nurses meant a reduction in the number of constant watches, Mr Davies advised that, if a doctor required an agency nurse, one was provided. However, budgetary controls meant they had to think first – it was a case of introducing some discipline into the process. Dr Yisa had not said it was an issue.

⁹⁹ In fact, Mr Davies was mistaken in the latter respect.

8.24 Mr Davies explained that the system for authorising constant observations moved from the doctors to Mr Monaghan and then to Mr Attard. Mr Attard had sole responsibility for taking on agency nurses – unless there was a need for a doctor to take such a decision late at night. This meant that Mr Attard effectively authorised constant observations, insofar as they required agency nurses in order for them to be carried out. However, he said that there was little real difference in the quality of supervision between constant supervision and the level below. Mr Davies confirmed that, where constant supervision was identified as being necessary, it would be applied if possible. He explained that it was not in any case 100 per cent effective. It was not the easy solution that might be thought. He said the proper question to ask was not who could authorise constant observations, but whether sufficient consideration had been given to the matter.

8.25 At the hearing, Dr Yisa said he could recommend one-to-ones but they had to be approved by Mr Monaghan. However, he confirmed that there was no occasion on which his recommendation for one-to-one observations had not been accepted.

8.26 Mr Hayward told the hearing that decisions about the level of supervision would be made by the doctor and that it was generally the doctor who would decide on constant observations.¹⁰⁰ If the doctor was not available, the senior officer on the day could make a decision and then refer the matter afterwards to the doctor. He said that, if he thought there was a significant risk, he would place the prisoner on constant watch.

8.27 Mr Hayward said that, if a discipline officer suggested constant watch, he would go to see the prisoner and make a decision. In nine times out of ten, he would agree. However, the doctor would always be asked to approve the decision because technically it was a clinical matter. Mr Hayward confirmed that there were no difficulties over the process or the decision making.

8.28 Talking about the limits of his responsibility, Mr Richards said whoever was there would take any necessary action and then inform a manager afterwards. He said he was not going to leave the prisoner for 20 minutes while he looked for a manager for authorisation. He said a discipline officer could place someone on a 15 minute watch and in doing so would inform other staff. Prisoners in the healthcare centre were in any case observed every 30 minutes. It was just a case of saying the particular prisoner should be observed every 15 minutes instead. He said he would note the change on the F2052SH, tell colleagues, and write something on the landing board (which included various details about the prisoner, including the levels of watch and unlock procedures) and in the observation book.

8.29 Mr Richards said it was open to him to suggest a one-to-one watch and that, if he thought this was necessary, he would contact the duty governor to

¹⁰⁰ This is in accordance with Standing Order 13. It goes on to say that “exceptionally” the nursing officer in charge may order the use of special supervision. This rests authority specifically with healthcare staff.

explain his concerns. (Mr Leane put this differently. He said he had no authority to implement constant watch but would relay his concerns to someone who had. I take this to amount to the same thing, albeit Mr Leane might have been more reticent about making suggestions.) He said such a proposal would normally be acted upon. If he had any concerns he would report them to the senior officer. In addition, he was in constant contact with medical staff. He could speak to them about his concerns and to their line managers.

8.30 Mr Smith told us there was a range of options for those at risk of self-harm, but constant watch had to be authorised 'at a higher level' because of the staffing implications. PSN Boateng said all prisoners on the healthcare centre were subject to 30-minute observations, regardless of perceived risk. The doctor decided whether an individual should be put on one-to-one watch.

Location

8.31 Mr Hayward said the doctor in reception would decide where the prisoner was to be located. Decisions as to allocation within the healthcare centre were also for the doctor, and he or she would always be consulted before anyone was moved from a landing to the ward. The same was true of movements the other way. The exception was where the prisoner posed a danger to others. Mr Hayward added that, where a doctor was not available to make a decision, he or she would be informed subsequently of what staff had done.

8.32 Mr Richards also said a doctor or a nurse would decide where in healthcare a prisoner should be located. It was not usual for him (Mr Richards) to make such a decision himself – a senior or principal officer or a senior clinical person would usually take it. A discipline senior officer could move someone to the ward. Mr Richards said he could not move a prisoner to an AS cell unless no manager was around to authorise it and the prisoner's own cell was simply not fit for habitation. He said there were times when they simply had to react to the given situation, but normally moves would go through management. Similarly, an officer could move someone from the ward to a cell in an emergency, but usually this was for the doctor to decide. However, if the prisoner was being disruptive, an officer would have to act immediately. He said the move to the AS cell would not necessarily depend on input from the doctor, but the doctor would be informed as soon as he arrived.

8.33 Mr Leane said managers decided where prisoners were located. This could be either on the nursing or discipline side at or above senior officer level. Nurse Japaul agreed with this interpretation. She said nursing staff would discuss the appropriateness of putting someone in the AS cells with the doctor or manager on duty.

8.34 PSN Smith told us that use of the cells was authorised by the doctor and duty governor, but Mr Hayward said whoever was in charge of the landing would make the decision if it was an emergency. However, if the move was

planned, the decision would be made by the governor or medical officer. The IMB also monitored usage. Mr Parry told us, however, that there were no structures in place to determine who went in or came out.¹⁰¹

Consideration

8.35 Professor Rogers noted that it was the discipline officers (“non-clinically trained staff”) working in the in-patient ward who were making the decisions as to how to settle and reassure D following the phonecall on 27 December and, more particularly, “the most critical of decisions, that surrounding observation levels”. He suggested that, “the Inquiry should carefully consider the level of responsibility and power that non-mental health trained professionals have in the decision making of prisoners who are more than likely not to have a mental health disorder.”

8.36 The point was repeated by Ms Stern in her closing submission. She said:

“The system in place at HMP Pentonville at the relevant time suffered from a number of systemic failings within the healthcare wing for the management of mentally ill or psychiatrically vulnerable prisoners. In particular, there was an emphasis upon discipline at the expense of clinical care. Management of mentally ill or vulnerable prisoners did not involve a cohesive clinical approach. This can perhaps be exemplified by the fact that much of the decision-making in relation to D was by discipline staff, who did not have access to his Inmate Medical Record ... That situation is fraught with problems, and was a contributing factor to the failure properly to act upon all relevant information in relation to D, in particular, in relation to the failure to ensure that he was seen by a psychiatrist, and the lack of proper heed given to the developments on 27 December 2001...

“... the clinical decisions in relation to D on 27 December 2001 were all made by discipline officers with no healthcare involvement, and without reference to any nursing care plan.”

8.37 However, Dr Cumming said this criticism overlooked the fact that many officers had some rudimentary clinical training and this arrangement was “very much an integral part of healthcare”. He suggested that the natural extension to Professor Rogers’ argument was that prisons would need to be staffed by nurses, given that some 80 per cent of prisoners had some form of mental illness. Dr Cumming argued that, “complex and challenging patients such as D require a multi-disciplinary response which includes a broad range of personnel, including security.”

8.38 Dr Cumming also said that, although tension existed between clinical and discipline staff, it was “possible to give this too much importance and

¹⁰¹ I asked for records relating to AS cell use. None was forthcoming. It was not clear whether none had been used or whether these records too had been lost.

does not necessarily mean that clinical care was impinged upon or compromised.”

8.39 Mr Eadie suggested that, “the changes were both necessary and successful in terms of making a significant improvement in healthcare.” He suggested that Dr Yisa’s recollection of a shift from healthcare to discipline may have been coloured by his not being “enamoured” of the new regime. He noted that Mr Hayward considered that the introduction of discipline officers offered “some sort of stability within healthcare at the time,” and that those officers undertook many of the task healthcare staff had been unhappy about doing.

8.40 Commenting on Dr Yisa’s criticism of the staffing mix, Mr Eadie said:

“Balances needed to be struck in terms of deployment of staff. The view before the changes was that excessive use had been made of agency nurses, and that the mix between healthcare and discipline staff was not delivering best results. The limited resources available needed to be deployed in the most effective way possible. Management judgements needed to be, and as appeared from the evidence of Governor Davies and John Attard were in fact, made.”

Mr Eadie also noted that Mr Attard had said the overall staffing complement increased as a result: “considerable time and trouble was spent seeking to ensure the most efficient and effective make up of staff.” Mr Eadie added that the list of staff present on 27 December showed “there were a number of qualified psychiatric nurses on R1.”

8.41 Ms Draper said there were two groups of staff with different functions in the healthcare centre. They were difficult to blend, but this was not unique to Pentonville. The environment was very different to what clinicians were generally used to, but it was possible for the two disciplines to complement each other. Ms Draper explained that the Prison Service had tried during the 1990s to operate with two groups of staff within the healthcare environment, and that the best nurses she had seen had also done officer training. She said they had a greater understanding of the work.

8.42 Ms Draper said the role of discipline staff was the same wherever they operated but that their interaction, access to the IMR etc, was different. They would see the prisoner on a 24-hour basis and could make major contributions to clinicians’ understanding of each patient.

8.43 In my view, there is clear evidence that the introduction of discipline staff to the healthcare wing brought significant benefits. Given current concerns about cleanliness in NHS hospitals, I do not underestimate the effect that proper cleaning and tidiness brought. Likewise, the advantages of greater authority and discipline on the wards (also a current concern of the NHS). Finally, there was the simple fact of adding to the total number of staff on duty in healthcare. Nevertheless, any concern that clinical care was somehow diminished, or that decisions that should properly have fallen to

clinicians were now being taken by discipline staff, should rightly be scrutinised.

8.44 Evidence relating both to who could locate prisoners and who could determine levels of watch is far from clear cut. (This might of itself lead to concern – as it did for Ms Draper – that staff were not clear about their powers in these respects.) My interpretation of the evidence is that the doctor had to authorise changes to both location and levels of observation. However, on a purely practical level it was not always possible to seek authority before acting. Indeed, in a prison environment, it would have been reckless to have done so. The reality was that, in some instances, staff had to act first and seek authority afterwards. It seems to me that this was both pragmatic and sensible.

8.45 Concern has also been expressed that non-clinical managers effectively controlled what clinicians could do via the purse strings. That is, that decisions about one-to-one watch were determined by financial not clinical imperative. I do not believe this was the case. There was no suggestion from any quarter that cost meant that a clinical decision was overturned. However, I do not think that managers should be criticised for having concerns about the cost of particular practices. In effect, the doctor authorised one-to-one watch clinically and the manager authorised it financially. I believe this was entirely proper.

8.46 More generally, with the introduction of IG 1/1994, the policy of the Prison Service had developed from a primarily medical model of suicide prevention towards an integrated approach based on the responsibility of the whole prison community for the care of those in distress. This recognised that many of those at risk had no clinical symptoms that could be treated. They simply had to be helped to cope with whatever was making them feel suicidal. It followed from this 'new' approach that discipline staff were routinely making decisions about the care of at-risk prisoners, including such matters as where they were located, what level of watch they were on (if any) etc. The responsibilities of the discipline staff in the healthcare centre at Pentonville were not exceptional.

8.47 On the face of it, D's suicide attempt appears to have been triggered by a specific relationship problem rather than a clinical matter. It was exactly the sort of situation that might be encountered on any prison wing. How to manage D following receipt of bad news was a matter entirely within the competence of discipline staff.

8.48 Of course, there may well have been clinical aspects to D's presentation. Decisions that might be appropriate for a discipline officer to take in relation to a healthy prisoner might not be appropriate in the case of a prisoner who was mentally ill. But the fact remains that staff on the spot had to make decisions until a doctor could be consulted. Whilst it might be argued that the staff in question should have been psychiatrically trained healthcare professionals, the same situation would have applied on the wings (which held many prisoners with mental health problems). In any case, to maintain

that discipline staff should not have been introduced into the healthcare centre would be to fly in the face of evidence that clinical staff alone simply could not cope.

8.49 Prisons are not hospitals, and prisoners may behave in a manner very different from patients in other healthcare settings. The inadequacy of relying exclusively on healthcare staff had been clearly evidenced by the lack of order in the healthcare centre before the discipline staff were introduced. This change was necessary to the safe running of R wing. But it follows that, if discipline staff were present, they would sometimes be placed in positions where they had to make decisions. (There is also evidence that nursing staff had in the past been reluctant to 'deal' with prisoners who were challenging or aggressive.) In respect of the particular decisions taken on 27 December 2001, it is worth noting that Mr Hayward was a trained healthcare senior officer (and, in my judgement, a particularly committed and conscientious one).

PART IX – MENTAL HEALTHCARE

Context

9.1 Mr Davies explained at the public hearing that the prison had an annual turnover of some 45,000 prisoners. This translated into 9,500 new prisoners each year. Of these, 13 per cent had an acute mental illness that would normally warrant confinement in a medium secure unit. Mr Davies said Pentonville did quite well in terms of referrals in a climate where care in the community in fact meant care in prisons. He described this as a national disgrace. He also said Pentonville detoxified 3,000 prisoners per annum – more than the NHS in the entire South East of England.

9.2 His former deputy, Ms Kringle, said some of healthcare's difficulties were caused by having to deal with so many prisoners who should not have been in prison at all. It was also difficult to move prisoners through the system. For example, it took months to move out those prisoners who were sectioned. This caused frustration. Ms Kringle estimated that three-quarters of those in the healthcare centre had mental health problems.

Adequacy of mental health provision and systems

9.3 Sir David Ramsbotham noted in his 1999 inspection report that the great majority of in-patients in healthcare were suffering from mental illness, and that Health Care Standards required “a doctor who is psychiatrically qualified” to have responsibility for mental health care. The Chief Inspector interpreted this as someone whose name was on the psychiatric specialist register, but he found that in-patients at Pentonville were under the care of certified GPs. His report continued:

“Many [in-patients] had been referred to visiting specialist psychiatrists for their opinion and the arrangements for this were better at Pentonville than at many other prisons since the visiting psychiatrists reviewed their in-patients regularly – if need be, weekly.”

The speed with which the senior medical officer was able to arrange for the transfer of seriously mentally disordered offenders into the NHS (“where they should have been sent in the first place”) was judged to be the one redeeming factor of the healthcare centre. Sir David considered that the visiting psychiatrist arrangements worked well: “it was notable that transfers of mentally disordered patients to the NHS were considerably quicker than in many other prisons.” The longest wait in the continuing audit of transfer was three months. Sir David said this was “a tribute both to the visiting psychiatrist arrangements and to the willingness of local NHS services to accept patients from prison promptly.” Nevertheless, the Chief Inspector concluded that it was doubtful whether the set-up at Pentonville was likely to promote as high quality healthcare as that envisaged in the Health Care Standards. Notwithstanding the prison’s comparative success in securing transfers, “far too many severely mentally ill offenders end up as in-patients at Pentonville

when admission to the NHS would be more likely both to meet their needs and to ensure public safety."

9.4 By 2002, the Inspectorate had noted further improved access to appropriate mental healthcare: "Pentonville had a better working relationship with its local NHS secure services. Mentally ill people were not languishing in prison to the same extent as they had been."¹⁰² The 2002 report said, "There were very good links with local psychiatric services both at secondary and tertiary level. The recent introduction of the initial elements of the community mental health team in-reach service was commended but was yet to reach its full potential."¹⁰³

9.5 The Board of Visitors had said in its 2001 report that there was good access to specialist mental health services through the provision of a forensic psychiatry service four days a week, and that other visiting psychiatrists and psychologists covered from Monday to Friday. The Board noted that it had been accepted that a more comprehensive mental health service was needed for the prison population generally, and funding had been agreed with Camden and Islington Health Authority. Plans were also in place for the recruitment of a mental health team. This would include a consultant psychiatrist. Nevertheless, the Board said that, when NHS beds were needed for seriously ill and disturbed prisoners, the waiting period was "considerable". This had the unfortunate effect of making heavy demands on staff time, "for example, up to six members of staff can be overseeing one inmate."

9.6 We spoke to Dr Robert Halsey about his role at Pentonville. He said the set-up was complicated. The Trust for which he worked was commissioned by the local Trust (Camden and Islington) to provide both psychological and psychiatric services to Pentonville and Holloway. He said the same arrangement obtained in 2001, but there had been no formal contract then. The process had evolved over time. Links were being made during 1999 - 2000, but there had been mental health input for a long time before that.

9.7 Dr Halsey noted that the Prison Service's involvement with psychology and psychiatry reflected how healthcare is organised in prisons – it was quite different from systems in other healthcare settings. Ordinarily, he operated at the tertiary level of service in that he received referrals from secondary services – that is, psychologists etc. However, referrals from prisons came from the primary service – the prison GP. He said there was a lack of clarity on the part of the Prison Service as to what a tertiary level service could provide.

9.8 Dr Cumming noted that Pentonville did not have a service level agreement for psychiatry services in 2001, but said this was then quite

¹⁰² Mr Davies said this was entirely due to Dr Yisa who was an excellent negotiator. He said he was very energetic.

¹⁰³ As noted earlier, Mr Tony Madden, an NHS manager, took up post as healthcare manager at Pentonville in December 2001 and started putting together a mental health in-reach team. The team did not become fully operational until mid-2002.

common. Instead, and akin to many prisons, Pentonville bought in sessions that they increased according to demand. Dr Cumming commented that, at the time, general adult psychiatry had a very limited presence in prisons. The sessional basis of service provision caused lack of continuity which the prison attempted to bridge by using a booking system. However, Dr Cumming's own experience was that those with the greatest need would always be seen first.

9.9 Mr Attard told the hearing that between five and eight psychiatrists and four psychologists attended the prison from Camlet Lodge. These were over and above the complement of regular sitting psychiatrists who did a couple of sessions each per week. Mr Attard said there was a lot of psychiatric and psychological (forensic and other) input from outside the prison. In addition, there were two psychiatrists employed by the prison and a consultant psychologist.

9.10 Former PSN Ansong took a more negative view. He estimated that about 90 per cent of the healthcare population was mentally ill (including depression, psychosis and anxiety). He said the prison did not employ any psychiatrists and that provision from outside was insufficient. Visiting consultants were only available on a Monday to Friday 9 - 5 basis. This meant that there was no-one available to deal with crises outside these hours. The consultants came from different catchment areas and dealt only with people who originated from their particular area. He was also critical that Pentonville's GPs did not have mental health backgrounds.

9.11 PSN Japaul thought the level of provision of psychiatric and psychological input in 2001 was high, with forensic psychiatrists and psychologists visiting every day. She said there were three or four of them – perhaps more. She thought they also had CPNs in the prison all the time.¹⁰⁴

Referrals

9.12 Ms Draper noted that a number of referrals had been made to mental healthcare specialists with respect to D, but she found only two actual listings (on 4 and 19 December), neither of which had resulted in him being seen.¹⁰⁵ Ms Draper noted that social workers had since been introduced to ensure that referrals were followed up, but she was “not at all convinced” that even the new system was in any way foolproof.

9.13 Dr Ranaweera told the hearing that, for in-patients, the clerking doctor would decide which sort of psychiatrist the patient needed to see and document the decision in the IMR. The doctor would then go to the administration office to find out who was next available, and arrange with the staff there for the patient's name to be put on the relevant list. If for some reason the patient was not seen, another psychiatrist could see him. It would be for the allocated doctor to identify where this did not happen and put the patient on another list. However, administration staff could also do this

¹⁰⁴ In fact, this seems unlikely – see footnote 103 above.

¹⁰⁵ This does not necessarily mean that D was only listed twice. He saw Dr Halsey on 18 December without a corresponding listing being found.

without first referring to the relevant doctor and could ask any psychiatrist to see the patient.

9.14 Dr Ranaweera said that arrangements were later introduced so that the doctor would fill in a form and take it to the administration office. The Mental Health Inreach Team then allocated the patient to a specialist having identified his particular needs. Previously, arrangements could be made for someone else to see the patient if he was missed. Dr Ranaweera said there were weaknesses in the system during its introduction.

9.15 When he was interviewed by Ms Draper, Dr Yisa was not certain under which system D would have been referred (though it seems certain it was the old system). He said that, under the old system, the doctor made the referral and nurses ensured the patient was seen. The new system (which he thought was brought in because he was perceived to have been wasting money) passed control of referrals to the community psychiatric team (although they were not fully in place at D's time). The team allocated each case to a particular doctor. Dr Yisa said this could not subsequently be changed if the patient was not seen for some reason. He considered this unacceptable and that, if there was a delay, the services of the next person available should be secured. In addition, since some continued to use the old system and some did not, the effectiveness of the system depended on who was on duty.¹⁰⁶

9.16 Mr Attard said there were daily consultations with specialists and that Dr Yisa was in the lead on referrals. Each doctor would write in the call up books who was to be referred, and this should have been picked up and actioned by administration staff. No single person was responsible for co-ordinating the process, but the SMO should have picked up on his twice weekly rounds where people were falling through the gaps.

9.17 Dr Yisa suggested that it would have been entirely reasonable to request to see a psychologist within a week. If this had not happened, it should have been documented. He could not recall any other incidents where patients had not been seen following referral. Sometimes they were not seen as quickly as they should have been, but they were usually seen within a reasonable time. D was wholly exceptional in terms of the number of referrals made and not followed up. Although it should have been apparent that D had not been seen, Dr Yisa suggested that the referral might not have been implemented if the entire landing staff comprised discipline officers. However, Dr Yisa refused to accept that D had not been seen.

9.18 Dr Ranaweera explained that whoever first saw the prisoner on reception would become that prisoner's allocated doctor. Hence, while

¹⁰⁶ The introduction of the new system to D may or may not be relevant. The new system was introduced by Mr Tony Madden who did not join the healthcare team until December 2001. The full in-reach team was not in place for some time thereafter. It seems probable, therefore, that D was referred under the old system. This was certainly the view of Dr Halsey, who noted that D's referral came direct from Dr Ranaweera rather than via the mental health in-reach team.

healthcare worked on the basis of team work, the allocated doctor would be responsible for monitoring the care given.

9.19 Opinion was divided over the efficiency of the referral system. Some staff who gave evidence considered that the system worked very smoothly and that those with mental health care needs were given high priority and received a lot of input from visiting specialists. If patients were on the list to be seen, they were seen. If anybody was overlooked it was more likely to be someone from the wings rather than someone who was on the spot.

9.20 However, Mr Ansong said the referrals system did not work well because patients would have to wait until their psychiatrist visited to see someone. If they missed that session for some reason, they would have to wait a further week. There were delays in getting people sectioned.¹⁰⁷

9.21 PSN Smith said there could occasionally be delays in prisoners receiving psychiatric care because of domestic reasons – that is, lack of staff to carry out escorting duties. He agreed that administration was stretched and accepted that the odd referral went astray, but said they did not go missing on a daily basis.

9.22 Mr Attard said it was quite likely that some referrals were overlooked. Requests by doctors were not always picked up and the decision making itself was laboured with a variety of people being involved. This could result in weeks not days passing before a course of action was decided upon/agreed. Mr Attard said no mechanism was in place for determining why patients were not seeing mental health specialists as planned, but it could be for many different reasons. These included the prisoner declining (in which case there should have been a note on his record), collecting his canteen (which was very important to prisoners), on a legal or a social visit, at the gym (a common reason for non-attendance), at class, or because staff could not find the prisoner's IMR.

9.23 Mr Davies told the hearing that the arrangements for referral following a recommendation were straightforward and there should not have been any difficulty. Mr Davies said he would expect someone on the list to be seen – but it was possible that they might have gone to court or been discharged, the prisoner might have declined the referral, or the psychologist might not have turned up. He agreed that he would expect any refusal to attend to have been recorded in the IMR. Challenged on the effectiveness of the referral system, Mr Davies described healthcare administration as very fragile, with piles of files everywhere. He said it was difficult to find things.

9.24 Dr Cumming said he could only speculate why D was not seen by a psychiatrist but thought it reflected the complexity of the process and “would expect it was not uncommon”. In sum, mental health services were “very much an adjunct to care,” and prison clinical staff simply had to manage with what they had.

¹⁰⁷ It seems likely that Mr Ansong is referring to the system post D.

D's referral to psychology

9.25 Dr Halsey explained that the form on which the referral was made was a standard one in use at the time. It was marked 'Urgent' in manuscript at the top, but about 90 per cent of referrals were so marked.

9.26 However, Dr Ranaweera said she would not routinely write 'Urgent' on a referral merely to 'geed up' the service. It was important to work as a team and people would soon get wise to it anyway. She said she would have written 'Urgent' because she wanted D to be seen sooner than if he had had to wait for a routine appointment.

9.27 Dr Halsey speculated that the fact he saw D within about two weeks might have been as the result of a special request or it might simply have been a quiet period.¹⁰⁸ He said it was difficult to prioritise cases and this was something he did only rarely. This might be when the referring doctor made a special case, usually at a face to face meeting. Usually, all he had to go on was the written information on the referral form. Reading from his letter, he noted that D had a number of problems with regard to alcohol abuse and self-harm. He was on an open F2052SH. He said the issues presented by D were 'bog-standard,' and added that it was not unusual for people referred to him to be on open F2052SHs. Large numbers of those referred had self-harm issues, a history of self-harm or were currently at risk.

9.28 Dr Halsey told the hearing that the D referral indicated complex needs that were not easily definable. There were three or four separate problems – alcohol, a history of mental health problems, a high degree of self-harm and relationship problems. He inferred that an arrow on the form (indicating there was a need for counselling in this area) referred to all four issues. Dr Halsey explained that his assessment would be made over several sessions. The initial session normally lasted about 25 minutes.

9.29 In preparation for a consultation, he would find out as much as possible about the patient. As a minimum, he would expect access to the IMR (although this was sometimes not possible) which might include a medical management plan. If available, he would read the whole IMR before seeing someone. He would also discuss the case with staff and might refer to the F2052SH. He would not have seen the wing observation book.

9.30 The consultation took the form of a discussion between him and the patient, the purpose being to elicit information so that he could form a judgement. The particular content of the discussion would depend on the nature of the referral. Another purpose of the meeting would be to try to

¹⁰⁸ Conversely, Dr Yisa considered the two week delay in seeing Dr Halsey surprising. He explained that in-patients took priority over others and that self-harmers would have been top priority. Dr Halsey visited twice a week and another psychologist also visited. Dr Yisa said nurses would have grabbed the next psychologist to have come through the door (this might account for Dr Halsey seeing D when he was not on the list for that day). He added that Dr Ranaweera was very pushy with regard to her patients' needs and suggested that D had not been fit to be seen the previous week.

assess the patient's ability to benefit from ongoing psychological input. Hence, the manner of the patient's response was also important.

9.31 Dr Halsey said interviews were conducted in offices (converted cells) on the wing. He said that it was necessary to make patients feel as relaxed as possible if they were to talk about trauma, abuse etc, and that it was difficult to imagine a worse setting in which to conduct an interview or try to establish rapport with someone. He said it was an inherently unsafe environment, which, as a consequence, restricted the type of interview that could be carried out. Some interviews had to be cut short because of the way the prisoner presented. In hospitals back-up from trained staff would always be on hand if the patient became upset or violent. This in turn created the confidence to ask very searching questions. (Dr Halsey implied that this was lacking in the prison.)

9.32 He said he would record both the fact of the consultation and his conclusions in the IMR. He would also consider writing a formal letter detailing the outcome of his interview. This happened in almost every case, but only once the whole assessment was complete. The letter of 25 January 2002 effectively closed the case (in light of D's admission to the Royal Free Hospital). The body of the letter consisted of what D had told him and would also have been recorded in the IMR. There was no plan because the assessment was not at that time complete.

9.33 I conclude that the referral system as it related to psychology worked effectively – indeed D was seen quickly and probably much sooner than he would have been on the outside.

Was D assessed by a psychiatrist?

9.34 Dr Yisa recollected giving D emergency sedation on 4 December 2001. He said D must have reached a certain level of risk for him to have administered it. As such, it was a significant event. There was a protocol to follow afterwards – this included regular observations and an urgent referral to a psychiatrist. It was the nurses' job to ensure this happened. Dr Yisa said that, following the written referral on 4 December, nurses would have approached the first psychiatrist they saw, having noted the referral in their own notes. Dr Yisa said he believed that the referral had been effected.

9.35 Although urgent referral was part of the protocol following emergency sedation, Dr Yisa had formed the view that D was in need of both psychiatric and psychological assessment. He said they wanted a number of decisions about him – for example, whether he was sectionable. He also wanted a diagnosis.

9.36 Asked whether it was likely that D had not seen Dr Akinkunmi on 5 December because he was still sedated, Dr Yisa suggested that D might in fact have been seen, but by a psychiatrist other than Dr Akinkunmi. He said that, if D had missed the morning session (because of sedation), he would have been seen during the afternoon.

9.37 Dr Yisa agreed that, when D was seen on 8 December, it would have been apparent to the doctor that he had not been seen by a psychiatrist. It should also have been apparent from the twice weekly case conferences. Similarly, the case conference on 13 December that noted that D was settled should have noticed that he had not been seen. Dr Yisa was convinced that D had been seen by Dr Hurst or one of the other visiting psychiatrists, even if he had not been seen by Dr Akinkunmi (upon whom they were relying more for transfers, as opposed to diagnosis and advice on management). Dr Yisa believed the medication prescribed to D was evidence of this. In his statement, Dr Yisa said:

“... I believe that Chlorpromazine was prescribed to D to help him sleep. Chlorpromazine was often prescribed in those days by many visiting psychiatrists as a major tranquilliser and sedative. This is why I suspect that D might have been seen by one of the visiting general psychiatrists.”

At the hearing, Dr Yisa said Chlorpromazine was a medication usually advised by a psychiatrist and was not something that doctors would normally prescribe of their own accord. It helped with dangerously impulsive behaviour and was particularly useful in the short term to quieten disturbed patients. It could also be used to help sleep. It was an anti-psychotic drug, but did many things (and would not be prescribed just to help someone sleep). Dr Yisa added that it was used principally for tranquillising patients where there were concerns about drug addiction.

9.38 Dr Cumming agreed that the prescription of both Venlofaxine and Chlorpromazine was consistent with D having been seen by a psychiatrist, as opposed to simply a GP. He suggested it was consistent with an interim prescription pending D being formally assessed. However, he also acknowledged that some GPs would prescribe the drug in any case.

9.39 Professor Rogers said that, whilst it was appropriate to prescribe Chlorpromazine as an anti-psychotic, it was not reasonable to prescribe it without a diagnosis having been made. It was one of the most common anti-psychotic medications, but Professor Rogers thought it likely a GP might prescribe it to help the patient sleep.

9.40 Dr Yisa said that, if he had thought D had not been seen by a psychiatrist or psychologist by 13 December, D's attempt to hang himself would have rung alarm bells and he would have been straight on the phone to organise it. He would also have made notes about the care plan to follow. Dr Yisa repeated, however, that it would have been extremely unusual for someone to have been given emergency sedation but not have been seen by the psychiatrist.

9.41 He said the allocated doctor would have been aware of the hanging and the previous referrals on 14 December. He suggested again that D might have been seen by one of the other visiting psychiatrists, but that Ms Draper

had perhaps not identified them as such from the IMR because of difficulties with their handwriting. (Dr Yisa confirmed that Dr Halsey would have had access to the IMR and made entries in it. He suggested that he too might not have recognised the handwriting to know whether D had in fact already been seen by a psychiatrist.) He added that it was inexplicable for D not to have been seen, and agreed that D should have been seen long before 19 December.

9.42 Having said that, he advised that Dr Ranaweera was the most meticulous of all the medical officers at keeping records. Dr Yisa said that if it happened, she would have documented it.

9.43 He went on to note there had been a change to the referral process in an effort to streamline it. This meant that a patient could only be seen by the specific specialist for whom he had been listed. The safety net of flexibility between specialists had therefore been removed. He also implied that the reduction in the nursing complement from 23 to 12 might have been a factor.

9.44 Dr Ranaweera judged that D might have been referred to Dr Akinkunmi (a visiting forensic psychiatrist) because of the nature of his charge. The forensic psychiatrist would also become involved where a transfer to a secure mental facility was required. Dr Ranaweera reiterated that, given the system that operated with regard to nurses, an allocated doctor, and the ward rounds, it should have been identified if someone was not seen and steps taken to ensure they were.

9.45 Dr Ranaweera also thought D might have been seen by psychiatrists other than Dr Akinkunmi. She noted that there was a lot of safety netting in place to ensure that would be the case. Taking into account all the circumstances, she said she would be very surprised if D had not been seen by a psychiatrist. If he had not seen Dr Akinkunmi, it did not mean he could not have been seen by someone else. D's violence made the referral urgent. Both Dr Hurst and Dr Hadjiou were available most of the week.

9.46 Nevertheless, Dr Ranaweera confirmed that if someone was seen by the psychiatrist there would always be an entry in the IMR. (Unless the IMR was not available for some reason. In that case, a continuation sheet would be used and the two married up when possible.) This would be the case regardless of whether any action resulted. It would also have been documented in the F2052SH as part of the case review record.

9.47 Dr Ranaweera said the psychiatrist would normally make an entry in the IMR. However, if he had concerns, he would discuss them with the SMO, allocated doctor or nursing team. It followed that the allocated doctor would therefore have known if a consultation had taken place and what the view of the specialist was.

9.48 It does seem incredible that D could have been in the healthcare centre at Pentonville, and the subject of several urgent psychiatric referrals, without actually having been seen by a psychiatrist, especially in view of the

frequency of their visits. However, Ms Draper could find no record of such an event. IMRs are notoriously difficult to read, but I cannot imagine that she could not decipher a single entry by any of the psychiatrists or that, given her concern on this point, she did not check her reading of the IMR with anyone in the healthcare centre during her investigation.¹⁰⁹

9.49 Professor Rogers suggested that Dr Halsey would have checked whether D had already been seen by a psychiatrist before taking such “a bold step” as himself referring him to a psychiatrist. Hence, he thought it was likely that D had not been seen by this time. I am inclined to agree. I am mindful here in particular of Dr Ranaweera’s evidence that it was the practice of the specialists to feedback to the allocated doctor if they had any concerns. Dr Halsey clearly did. Had he spoken to Dr Ranaweera, I presume she would have told him if D had already been seen by a psychiatrist, thereby obviating the need for him to refer D himself.¹¹⁰

9.50 In addition, whilst Dr Halsey might not have recognised the signatures of the psychiatrists in the IMR, it does not seem likely that, having read their entries he would not have identified them as having been made by psychiatrists as a result of the particular issues considered and the language used.

9.51 Notes made at the Royal Free Hospital following D’s admission there on 27 December recorded that he was “awaiting psychiatric assessment”. This information would either have been taken from D’s IMR (which would have followed him to hospital) or been provided by prison staff.

9.52 Having said all that, it hardly seems likely, given the level of psychiatric provision available, that no psychiatrist saw D at all for the month he was at Pentonville. However, even if D was seen *en passant* by one of the other psychiatrists, it was clear that they did not conduct a full assessment as this would have been documented. I do not consider it likely that Ms Draper failed to recognise an IMR entry of this nature and (presumably) length. In addition, medical staff would have been aware that D had been assessed (or was being assessed) and would not have continued to refer him. In other words, if D was seen by one of the psychiatrists at the prison, their intervention was clearly inadequate because he continued to be urgently referred. It is possible therefore that they might have had input into dealing with a particular event (such as the emergency sedation), but it seems unlikely that any of them addressed the more proactive, long term aspects of D’s care.

Did it matter?

9.53 In her report, Ms Draper concluded:

¹⁰⁹ Ms Draper asked Dr Yisa about the referrals system, but did not ask him outright whether D was seen by a psychiatrist and if not, why not.

¹¹⁰ Dr Halsey confirmed at the hearing that he would have referred D, even if he had been seen before, if he was sufficiently concerned. However, he said he would have documented this. If the IMR had not been available to him, he would have written his summary on a separate sheet for subsequent linking.

“... if help had been given earlier, D may well have received more appropriate interventions and he may well have settled or been assessed as a different level of risk.”

9.54 Dr Ranaweera said a forensic psychiatrist would have been appropriate in D's case because of the access they had to outside psychiatric units. There might also have been an issue relating to the charge D faced (D was charged with possession of an offensive weapon). Dr Ranaweera noted that much was uncertain about D (there was no outside information about him at the time of the referral). But he had a history of access to psychiatric services, violent behaviour (he had already smashed two cells over the weekend), and self-harm. She advised that forensic psychiatry could lead more quickly to a transfer. In-patients would mostly be referred to forensic psychiatrists. This was partly to do with the question of sectioning but that was not the whole reason.¹¹¹

9.55 Dr Yisa told Ms Draper:

“... although [D] complained of voices in his head it was all the time he was upset about the separation from his family and the fact that he may lose his kid. So it was an emotional, psychological problem rather than a psychiatric illness ... he was somebody who was having an acute reaction ... He was somebody who needed psychology and counselling rather than psychiatrists and section although I think my advice was a referral to both of them stressing one, psychology.”

9.56 Dr Yisa did not confirm at the hearing whether he had identified possible psychotic symptoms in D. He said he was not a trained psychiatrist, but would expect any doctor to be concerned about someone exhibiting D's symptoms and behaviour and to refer him – hence the robust psychiatric cover at Pentonville. He said it was not appropriate to consider whether the symptoms were genuine. They had to take them seriously and arrange a proper assessment.

9.57 Dr Yisa noted that Dr Halsey's findings identified significant issues. However, they needed more detail and this was the purpose of the psychiatric referral.

9.58 Dr Halsey suggested at interview that the referral to a psychiatrist parallel to the referral to him might have been indicative of a fail-safe approach, rather than a judgement that D was mentally ill. He said there was a lot of concern at Pentonville about dealing with complex cases (of which D was one). It was difficult to determine to which service to refer patients because of the complexity of the presentation – they had multiple issues – and it was difficult to tease these out during a primary care interview with a

¹¹¹ At the hearing, counsel to the inquiry (Mr Morton) pointed out that a local document suggested patients would be referred to specific doctors (including Dr Akinkunmi) if they were likely to need sectioning. Mr Eadie noted that the document said 'may'.

GP. It was not uncommon for patients also to be referred to a psychiatrist. D was no different in this respect.

9.59 Dr Ranaweera was asked about this. She said that, where mental health issues were identified, a referral would be made to a psychologist and a psychiatrist. They did not routinely refer to both because they were scarce resources and had to be used carefully. She said D's home circumstances suggested he would have been in need of counselling. Where issues of self-harm presented, they would also refer to a psychiatrist to determine whether the patient was mentally ill. Where a patient was suffering from mild depression, for example, he would be treated by the doctor just as he would be treated by the GP on the outside. As noted, Dr Ranaweera inferred that D might have been referred to Dr Akinkunmi because of the nature of his charge. The forensic psychiatrist would also become involved where a transfer to a secure mental facility was required.¹¹²

9.60 Dr Halsey advised that it was not very common for him personally to refer someone to a psychiatrist, but he would do so if he was concerned. When pressed on how rarely this occurred, he could only say it was relatively infrequent and there would be particular circumstances that warranted it. In D's case, he might have been aware that a psychiatric referral had been made but had not yet happened. He might have been trying to push things along. Dr Halsey noted that there would be a gap over the Christmas period and he obviously felt it was necessary for D to be seen by a psychiatrist and did not want it to be too long delayed. His use of the phrase "Following day" suggested concerns above and beyond the generality. He noted in particular D's comments about suicidal feelings. He suggested that this must have meant he considered D at the higher end of risk. It was very worrying that D had previously responded to hallucinations. This put him in a high risk category. It was possible that the voices were a symptom of psychosis, but he wanted to discuss this with a psychiatrist.

9.61 Dr Halsey said it did not follow that he thought psychiatric input more important than psychological input. They worked in a multi-disciplinary team. D was clearly distressed and causing management problems. The nature of his problems was not clear. Psychiatric input would therefore have been valuable. It would have enabled an assessment to be made with a view to informing D's management.

9.62 Asked what difference a psychiatrist would make, Dr Halsey said they were specially trained to diagnose mental health issues. D's was a very complex presentation and he was difficult to assess. He presented a challenge to medical staff and it was not clear what his diagnosis was. Psychiatric input was necessary, especially in relation to possible medication. In summary, no diagnosis had been made in D's case and one was needed. It was necessary to know what you were trying to manage. Dr Halsey wanted

¹¹² Dr Halsey explained that powers to treat prisoners were more limited than in a hospital environment. The Mental Health Act did not apply in prisons, so the framework in which they worked was very different. Importantly, they had to have the patient's consent to treatment.

to discuss D with other mental health professionals. In light of D's behaviour, volatility and self-harm, he suspected borderline emotional unstable personality disorder. He thought that was probably what he had in mind at the time. However, a dual diagnosis of mental illness and borderline unstable emotional personality disorder might have been the outcome. It was possible therefore that medication might have been prescribed. However, this was not a diagnosis that would fall to a psychologist to make.

9.63 Dr Halsey said that, if a psychiatrist had seen D on 19 December, the ensuing plan would have evolved over time. It would have been an incremental approach. A plan would have been in place for the first few weeks and then adapted and changed. It might primarily have involved psychological input but also included medication. The psychological input would have consisted of weekly sessions to discuss the patient's difficulties and the use of psychological techniques and problem solving for coping with them.

9.64 In his report, Professor Rogers wrote:

"I am surprised at the clinical interpretation that medical staff within the prison took in relation to D's clinical presentation. The fact that D had command hallucinations clearly indicated the possibility of a mental disorder. However, this seems to have been given very little weight. I do not know why the medical staff did not consider the probability that D was suffering from a mental disorder at the time. Command hallucinations are a well recognised symptom indicating a mental disorder is present. There are occasions where a mental disorder may not be present when they are considered a 'pseudo' and not a 'true' hallucination. The distinction is made by a very simple question - whether the person hears the voices inside their head (a true hallucination) or outside their head (a pseudo hallucination). However, there is no evidence that this question has been asked. In the absence of this knowledge, I would expect any reasonable body of clinicians to err on the side of caution and assume that they were true."

Professor Rogers explained that there were many causes for command hallucinations (it was not necessarily a sign of mental illness) and this was why it needed to be assessed. He did not have enough information in D's case to determine what the problem was. However, even a lay person would be concerned by command hallucinations.

9.65 He said command hallucinations could be transient if they were related to a personality disorder, but if the cause was mental illness they would be more stable/consistent. D's self-harm could have resulted from the command hallucinations or might have been the result of a personality disorder. It was this that needed proper psychiatric assessment.

9.66 Professor Rogers said the fact that D only complained about command hallucinations on 4 and 18 December did not necessarily suggest staff were treating D appropriately. Without prompting, people often did not volunteer

information about hearing voices. On both 4 and 18 December D had reported the voices whilst being assessed. There were no assessments in between. He said D would not necessarily mention the voices without being asked unless he was very distressed and could not cope with them.

9.67 In Professor Rogers' opinion, "any reasonable body of doctors" would associate the presence of command hallucinations with a mental disorder where a prisoner is reporting hearing voices telling them to hurt themselves. This should have alerted prison staff to the "real potential" for future suicide attempts. He suggested that, in light of this, it would have been more appropriate for Dr Ranaweera to have referred D for psychiatric assessment rather than for an assessment by a psychologist for relationship problems. Professor Rogers clarified that it was not the fact that an act of serious self-harm had ultimately taken place that caused him to be critical that warnings were not being taken seriously, but the steps taken beforehand. That D did not see a psychiatrist was a real demonstration of this. He said it was correct always to err on the side of caution. Doctors should not have written off the risk so soon after an episode of serious self-harm.¹¹³

9.68 Professor Rogers referred to Dr Yisa's assessment of D as having emotional/situational problems rather than a psychiatric illness and commented:

"It is important to state that Dr Yisa is not a psychiatrist and based upon the documentation that I have reviewed his qualifications are not entirely clear. However, I have some doubt as to whether he is suitably qualified to make these decisions without specialist advice – that of a doctor trained in psychiatry."¹¹⁴

He said he did not agree with Dr Yisa's interpretation, and that D was "clearly reporting a psychiatric symptom (command hallucination) which is considered a psychotic symptom by any reasonable body of doctors". Professor Rogers suggested that Dr Yisa's descriptions of D's presentation all pointed in this direction. He also inferred that the medication Dr Yisa said he administered on 4 December was an injection of an anti-psychotic drug. In addition, he noted that D was prescribed Chlorpromazine and commented that this was a medication given to people suffering from psychotic symptoms and for those who suffered from schizophrenia. It too was classified as an anti-psychotic drug. Noting that Dr Yisa referred to D being prescribed Chlorpromazine because he was not sleeping well, Professor Rogers commented that the medication was not indicated for sleep problems. In fact, one of the side effects was insomnia and another was depression. He concluded:

¹¹³ The case review on 18 December concluded that D was not mentally ill or clinically depressed. He was anxious but not suicidal. He had attempted to hang himself five days earlier.

¹¹⁴ Professor Rogers said the wording on the referral form was clearly directed at the psychologist because of the reference to counselling. Taken together with Dr Yisa's assessment, it was clear they considered D's needs to be primarily psychological.

“I am unsure why Dr Yisa chose to give D an anti-psychotic medication and not a recognised sleeping tablet for his sleeping problem if he believed that the problems were not related to a psychiatric illness.”

Professor Rogers considered that medical staff focussed wrongly on D’s relationship problem, and failed to remedy this when Dr Halsey advised on 18 December that an urgent psychiatric assessment should take place as soon as possible. Professor Rogers said he was, “at a loss to understand why D was not urgently assessed by a psychiatrist the whole time he was in Pentonville,” noting that in his experience it was always harder to secure psychological input than psychiatric input:

“I am confident that any reasonable body of doctors working in a prison setting would be very concerned if all requested urgent psychiatric assessments of prisoners took longer than 24 days. I am therefore surprised that the lack of assessment was not more assertively followed up after at least two weeks in response to a request for an urgent assessment.”¹¹⁵

9.69 Professor Rogers suggested that, had a psychiatrist assessed D, “any reasonable body of psychiatrists would probably have concluded that D was suffering from psychotic symptoms ... [reviewed] D’s medication and commence[d] a clear medication treatment regime for those psychotic symptoms.” He considered this, “should have consisted of, at the very least, anti-psychotic medication, probably coupled with anti-depressant medication.” Finally, Professor Rogers said he “would also expect that any reasonable body of psychiatrists would have considered the possibility of transfer to a secure psychiatric hospital had D not responded to such medication.”

9.70 He went on to say that there were difficulties in managing the patient in the absence of a psychiatric assessment, and that a psychologist would not in fact be able to do much without the benefit of a psychiatric assessment. It was a question of the order in which things were done.

9.71 Professor Rogers considered a diagnosis of mental disorder was likely in light of D’s command hallucinations, but it would have needed a psychiatrist to have made such a diagnosis. This might have resulted in medication to address the hallucinations, and he assumed this would have helped if the hallucinations were caused by mental disorder. It was less clear if it would have helped if the cause was personality disorder, and especially borderline unstable emotional personality disorder. However, psychiatry was not an exact science and this was open to debate. Nevertheless, in light of the behavioural disturbance and suicide risk, he would have been surprised if medication had not been prescribed.

9.72 Professor Rogers noted that consideration of D’s condition was now all speculative. However, he was unhappy with the principle of personality

¹¹⁵ D was first due to be seen by Dr Akinkunmi on 5 December 2001. Because of Dr Halsey’s intervention, he was re-referred to be seen on 19 December.

disorder given D's youth. He thought it more likely there was something mentally wrong with him. He acknowledged that borderline unstable emotional personality disorder was the most debated condition of all, but the bottom line was that you had to treat the symptoms before you.

9.73 Dr Cumming did not set as much store by D's reported hallucinations which he said were just one aspect of D's presentation. Dr Cumming said enduring, persistent symptoms were suggestive of mental illness. If the voices were transient they could have some other cause – a result of detoxification, for example. Dr Cumming said that things were changing all the time and that it was necessary to look at the totality, not individual pieces of the presentation. This should include D's history before he went to Pentonville. Dr Cumming noted that there was no history of mental illness prior to D's admission to Pentonville, and that he is currently detained under the category of mental impairment. It was unlikely that D was mentally ill only for the period he was at Pentonville.

9.74 Dr Cumming did not accept that the command hallucinations were necessarily a symptom of psychotic illness. He said there was not enough information to make that judgement and did not agree that, given D's clinical presentation at the time, a psychiatrist would have concluded he was suffering from psychotic symptoms. A diagnosis of mental illness was not made on the basis of one symptom, "especially when his overall presentation and symptoms suggests other diagnoses".

9.75 Indeed, noting that the hallucinations were self-reported, Dr Cumming said there was no objective evidence of command hallucinations. They were also quite specific in nature reflecting D's particular concerns – they were contextual. This was slightly unusual and rather begged the question as to whether they were genuine. Dr Cumming asked what might be meant by "hearing voices". He said it was a few steps off a conclusion of hallucinations.¹¹⁶ He agreed, however, that it was not appropriate to wave away self-reported hallucinations – they should be discussed, probably with a psychiatrist.

9.76 Dr Cumming said self-harm "possibly" lent greater significance to command hallucinations, but the instruction to harm was just a type of hallucination. The key was assessment across the breadth of information available. Assessment was the starting point for future management. He agreed therefore that D should have been seen by a psychiatrist.

9.77 Dr Cumming did not consider that the Chlorpromazine prescription indicated that Dr Yisa had diagnosed mental illness. He agreed it was an anti-psychotic drug, but said it had other uses besides a treatment for psychosis. He said 50 mg was not a very high dosage and Chlorpromazine

¹¹⁶ Professor Rogers said there was a lot of debate about patients feigning or exaggerating symptoms for benefit. However, he noted that Dr Halsey did not appear to think D was making it up, as he would have said so had that been the case. The immediate psychiatric referral was also significant. Dr Halsey confirmed he would have made a written note if he had thought D was feigning his symptoms.

was good for reducing arousal and had a sedative effect. It was in more common use in this respect in 2001. It avoided using Diazepam which had quite a currency in prison. Dr Cumming noted that D had just completed his detoxification, and doctors would have been cautious about prescribing benzodiazepines thereby prolonging the detoxification process. He said Chlorpromazine could be used just as a sedative, though he noted this would not be good practice.¹¹⁷

9.78 The fact that D had been on Venlofaxine and Chlorpromazine did not alter Dr Cumming's view of D's 'diagnosis'. It was permissible for someone with a borderline personality disorder to be on these medications (although he acknowledged this was not commonplace). However, he said it would be wrong for him to diagnose on the basis of the medication prescribed.

9.79 Dr Cumming referred in his statement to the peculiar expertise of prison medical staff in dealing with prisoners. This was particularly so in the context of mental health. He noted Dr Yisa's reported success in securing transfers to hospital. This meant being able to persuade colleagues of need. Dr Cumming suggested that Dr Yisa and his team should be "seen as a gateway to mental health services," and that the viewpoint (for example, that of the case conference on 18 December) that D did not have a mental illness "should be given credence". Dr Cumming considered that their assessment was probably correct.

9.80 Dr Cumming inferred that the reason Dr Yisa had first mentioned psychiatry was:

"... probably a reflection of firstly requiring confirmation that D did not have a mental illness and secondly some sense of desperation to address the marked behavioural problems and self-harm that were evident in the earlier part of his remand."

He surmised that, as these issues appeared to recede, so the referral was seen as less pressing. Dr Halsey's later psychiatric referral might also have been aimed at excluding mental illness. Dr Cumming's opinion was that much of D's clinical presentation and behaviour could be "explained in terms of a diagnosis of an emotionally unstable personality disorder, borderline type." It was wrong to suggest that those with borderline personality disorder flipped in and out of psychosis.

9.81 Dr Cumming noted a relationship between personality disorder and self-harm, and suggested that concerns in this respect might have led to D's arrest and remand (as opposed to bail). The presence of personality disorder would most likely not be addressed by the NHS. The Prison Service had developed considerable expertise in managing such prisoners.

¹¹⁷ Dr Cumming endorsed the use of Chlorpromazine. He said that, apart from being an anti-psychotic drug, it was indicated as being used for "the short term management of acute agitation, excitement and violent or dangerously impulsive behaviour". He considered it a "good choice" with the management of D. It was also more appropriate in terms of D having just completed detoxification.

9.82 In conclusion, Dr Cumming considered that a psychiatric assessment would have made a limited impact upon D in terms both of his care and preventing his attempted suicide. Considering what his own approach might have been, Dr Cumming did not believe it would have made much difference. He noted the importance of time in enabling a prisoner to adjust.

Consideration

9.83 Ms Stern was very critical that D was not formally assessed by a psychiatrist. She commented:

“The system for referrals for psychiatric assessment and/or treatment was fundamentally flawed and/or failed woefully in the case of D. This is established by the fact that D was repeatedly referred for psychiatric assessment, at times on an urgent basis, but was not seen by a psychiatrist. This gross lapse was never apparently identified other than by Dr Halsey, the visiting psychologist, who saw D on 18 December 2001 and was sufficiently concerned to list D himself for the visiting psychiatrist the following day. Thus, whilst there was elaborate evidence as to systems in place to ensure people were seen (albeit that it is still not clear whether the referral in relation to D was under the old or the new system), this inquiry can only conclude that those systems were flawed in operation in the case of D.”

Ms Stern identified Dr Ranaweera, D's allocated doctor, as being responsible for the failure to follow through, arguing that she “clearly failed to comply with her obligation to ensure that D's proposed plan of treatment, i.e. assessment by a visiting psychiatrist, actually took place.”

9.84 She added:

“... there is a real prospect that a full and detailed psychiatric evaluation by the recommended visiting psychiatrist would have led to a combination of medication and treatment plan which would have had a real prospect of averting the outcome for D on 27 December 2001 ...

“His acute distress may well have been ameliorated by appropriate medication. Professor Rogers said he would have been very surprised if an attempt had not been made to treat his psychotic symptoms with medication, and to try to calm his behavioural disturbance, whatever the view as to diagnosis, particularly given that a firm diagnosis would take time.”

9.85 In contrast, Mr Eadie said, “There was a perfectly sensible and workable system in place for picking up referrals and ensuring that those who were referred were in fact seen.” This included a safety net for ensuring that

another psychiatrist would see patients if they were missed first time.¹¹⁸ He added that:

“... in order for the ‘not seen’ hypothesis to be accepted, it would have to be accepted that the systems, with all the safety netting built in, including the fact that it operated under the oversight of a careful doctor such as Dr Ranaweera, broke down not just on a single occasion but on multiple occasions. It is submitted that that is simply not credible as a hypothesis in the light of the evidence given. It is accordingly submitted that Dr Ranaweera’s conclusion – she was ‘sure he would have been seen by a psychiatrist’ – is the only sensible one on the evidence.”

He suggested that this was supported by the prescription of Chlorpromazine, and that evidence about IMRs not always being available provided a credible explanation as to why there was no record of D being seen. Mr Eadie questioned whether Ms Draper had in fact seen D’s IMR, adding that if she did, it was surprising she did not seek Dr Yisa’s assistance on it.

9.86 Mr Eadie noted that Dr Cumming did not consider D was mentally ill and that his assessment accorded with Dr Halsey’s “instinct at the time”. Mr Eadie added:

“This is important because there appear to be a number of suggestions by D’s representatives ... that D was mentally ill. The evidence, including his history before and after his time at Pentonville (the importance of which in any diagnosis is emphasised by Dr Cumming), does not bear this out.”

Mr Eadie commented that it was important to bear in mind the prison context when assessing the care provided to D. He referred to Dr Cumming’s evidence, “that the prison setting is an important factor and provides a very different backdrop than would be the case in the community.” Mr Eadie said:

“The evidence clearly supported this. A number of witnesses highlighted the numbers of prisoners with mental health difficulties going through a large local prison such as Pentonville. The challenges involved cannot be under-estimated. Those challenges are all the more acute in a case of D’s complexity and impulsivity.”

He added:

“Dr Cumming rightly emphasised that there was considerable expertise in healthcare. It might be tempting to proceed on the basis that in relation to a case like D’s that without psychiatric input (assuming that absence) the whole decision making process about care must have been flawed. That would plainly be wrong.”

¹¹⁸ Mr Eadie concluded, in light of Dr Halsey’s evidence to Ms Draper, that D was referred under the old system.

In support of this argument, he noted that:

- Dr Yisa had considerable interest and experience in mental disorder;
- a number of psychiatric nurses worked in healthcare;
- D was seen by a psychologist at least; and
- it was likely that D was not mentally ill (so any change to his treatment subsequent to a referral would probably not have been significant).

9.87 My own conclusions are as follows. First, I do not consider it appropriate to suggest that medical staff were not concerned by command hallucinations or did not treat them seriously (although they should undoubtedly have shown much more vigour in pursuing the psychiatric referral). On the other hand, I do not find convincing Dr Cumming's suggestion that the need for a psychiatric referral might have become less pressing as D's symptoms abated. The fact that Dr Halsey was so concerned on 18 December that he referred D himself undermines this proposition.

9.88 The point is that no-one knew what precisely lay behind D's problems, so this should have been thoroughly checked out. His propensity for self-harm made the matter urgent. It is entirely possible, as the Prison Service has suggested, that a psychiatric referral might not have offered anything in terms of managing D. However, it is equally possible that it might have done. We simply do not know. The possibility that it might not have made a difference is no vindication for the clear failures in this respect. Indeed, a referral might at least have ruled out mental illness. This would have enabled Dr Halsey to move forward from the point of his first consultation. In the event, he was stymied pending resolution of the matter.

Equivalence

9.89 D was seen by a visiting consultant psychologist 15 days after he was first referred. He was referred on the same date to a psychiatrist but, some 24 days later, had not been seen by one.

9.90 Dr Halsey implied that his seeing D within such a short timescale was unusual. He confirmed that the reply he sent to Dr Ranaweera suggesting that a consultation should take place within one month was a standardised letter for the prison. He said it was not always possible to meet the one month deadline. However, performance in this respect was difficult to compare with the position outside prison because referrals in the latter case usually came from community Mental Health In-reach Teams, not from the GP. Referrals from the In-Reach teams were usually seen within a few weeks. Overall, he did not consider there was any particular difference in response times.

9.91 Dr Yisa suggested that people got to see psychiatrists quicker at Pentonville in 2001 than they would now outside prison, except where there was a good mental health team in place.

9.92 Dr Cumming said he was “very concerned and dismayed” by Professor Rogers’ comments about equivalence of care. He said he failed to take into account the “high morbidity, risk, complexity and reality of delivering mental health care in prisons”. It was necessary to “ground ourselves in reality and consider what could have been done with the resources available in 2001.” He implied that equivalence was not realistic, but that healthcare delivery should be regarded as different rather than sub-standard. He went on to say that a 4 – 13 week waiting period to see a psychiatrist was the experience of most patients outside prison.

9.93 I agree. It was commendable that D was seen by a forensic psychologist within two weeks of being referred. There can be few instances outside prison where someone has access to this level of psychological care so quickly. As far as psychiatric referral is concerned, the general evidence is that Pentonville was very successful in having prisoners assessed and, where necessary, transferred to hospital. That D was not seen by a visiting forensic psychiatrist for a detailed assessment within four weeks of referral (which in any case would be exceptional outside prison) was nothing to do with equivalence. It was about a particular systemic – or perhaps individual – failing.

Current position

9.94 The healthcare manager, Mr Warren, said that, on his arrival at Pentonville in 2006, he found the mental health team functioning well and effectively. Nevertheless, he had secured funding for an extra staff grade full time doctor who was responsible for the care of mentally ill prisoners. The prison now had a dedicated mental health in reach team. A weekly referral meeting was held where each referral was given to an appropriate key worker. Urgent referrals were allocated to the duty worker on a daily basis and the duty worker could see the prisoner immediately if required. He said all referrals were checked every other day to ensure that any urgent cases were seen within 48 hours. The maximum wait to see a mental health practitioner was estimated at the time the statement was submitted to be around two weeks. Input from services other than those provided within the prison could be arranged via appropriate referral. A health psychologist was based in the daycare centre and the prison could access specialist psychology services via the prison’s own psychology department.

9.95 Professor Rogers told the hearing that there was greater equivalence of care in prisons since the NHS took over provision of healthcare. Access issues had improved. However, differences must remain because primary care was provided in the Prison Service with access to specialists. This was different from a hospital environment. He considered that the speed of access to specialists in prison compared quite favourably with the position in the community. However, if acute need was identified in the community, the person would be seen relatively quickly.

9.96 Dr Halsey’s evidence painted a much gloomier picture. He explained that a Service Level Agreement had been up and running for two or three

years between Islington and his Trust covering services into HMP Holloway and HMP Pentonville. However, in 2006 the clinical psychological service had been terminated for funding reasons. Service provision for Pentonville (but not Holloway) finished on 31 August 2006. He said this had left a huge problem professionally – with numbers of people left on the waiting list. Patients had been assessed but there was no-one to whom to refer them. The Trust had no plans to provide its own psychologists and, as a result, there was a vacuum. Dr Halsey emphasised that, over the eight years he had been going into Pentonville, he had seen hundreds of patients many of whom presented extremely complex cases involving self-harm, abuse etc. But the psychological service to these people simply no longer existed. Pentonville had tried to establish a daycare service that was nurse led, but they were not able to provide the type of specialist service that had gone before.

9.97 Dr Halsey told us that equivalence of care, which he said had been seen as so important five or six years ago, no longer existed. If someone required clinical psychological intervention in the community, they could access it. Pentonville prisoners had no such opportunity. It was inevitable therefore that care was worse now than it was in 2001. At that time, they had provided an excellent service comprising assessments, transfers to the NHS, and help for self-harmers and those with psychoses, sex offenders, traumatic brain injury etc.

9.98 Dr Halsey confirmed at the hearing that there had been no change in the position with regard to the provision of psychology services into Pentonville since he had first spoken to me in 2006. The North London Psychiatric Service remained involved but no clinical psychologists were deployed. Funding was no longer available as it had been stopped in 2006.

9.99 Given Pentonville's catchment area and the nature of its population, this gap in healthcare service provision causes me great concern.

I recommend that the Prison Service seeks urgently to secure forensic psychology services for Pentonville.

PART X – LESSONS LEARNED

Ms Draper's recommendations

10.1 It was not Prison Service policy in 2001 routinely to investigate incidents of self-harm. Nevertheless, and in light of the seriousness of the attempt, Mr Ifor Smout (then the Head of Investigations in the London Area Office) asked for a review to determine whether a full investigation was required. As we have seen, this was carried out by Ms Carole Draper, at the time a governor grade working as a Senior Investigating Officer for the London Area Office. Again as I have reported earlier, in the course of her review Ms Draper interviewed a number of staff and reviewed D's prison records including his Inmate Medical Record. She apparently reported her findings to the Governor in March 2002 and submitted her report to the Area Manager in July 2002. She made eleven recommendations in the report. The Area Manager directed that these should be incorporated with recommendations made in relation to reports on two actual deaths that occurred at Pentonville at around the same time.

10.2 Ms Draper's eleven recommendations were as follows (I have included her original paragraph numbers for ease of reference):

- 8.1 The system for referrals within healthcare, to both outside and visiting specialists and internal departments, should be reviewed and consideration given to obtaining examples of best practice from other local prisons;
- 8.2 Healthcare case conferences for F2052SH prisoners should be multi-disciplinary and the prisoner should be present during the discussion. Landing staff with day-to-day responsibility for the prisoners should also be present;
- 8.3 The removal from the landings of F2052SH documentation for such case conferences must be kept to a minimum and there should be no delay in the document being returned;
- 8.4 Pre-printed sheets for 15-minute watches should be withdrawn and accurately timed entries should be made by staff when they actually complete the observations;
- 8.5 Consideration should be given to the issue of anti-ligature scissors to all or at least selected staff who work in high-risk areas. In the meantime, the anti-ligature scissors should be relocated so that immediate access can be obtained by any member of staff should the need arise;
- 8.6 A document specifying the authority to introduce a 15-minute watch should be published to all staff;

- 8.7 All serious incidents of self-harm should be reported at the time and, when necessary, contact made with the next of kin without delay;
- 8.8 Post-incident care and debriefings should be made available to all staff after such incidents;
- 8.9 When agency nurses are involved in serious incidents, a healthcare manager should advise the agency as soon as possible and offer any necessary support;
- 8.10 The position of the training in resuscitation techniques should be evaluated and consideration given to referring the issue to the London Area taskforce for advice and/or discussion held with the local primary care group regarding its development;
- 8.11 A thorough review should occur, if it had not already been done, of the healthcare documentation systems to ensure that documents are maintained accurately, can be located and are securely located in the event of an incident.

10.3 An action plan was drawn up in relation to the two actual deaths. This was as follows:

- Nursing staff in reception were to check all PER forms in relation to comments to prisoners being at risk;
- In-possession medicine policy to be reviewed;
- Staff to be trained in recognising certain behaviours and including better quality of information in F2052SHs. A training package to be developed for agency nurses;
- Duty governors to carry out hot and critical debriefs after a death;
- A named Care Team Co-ordinator to be identified for a particular incident;
- To put in place a policy to meet prisoners' and particularly cell mates' emotional and property needs;
- Case conferences to provide quality of information and to be regular and on time;
- All incidents of self-harm to be noted in F2052SHs and a record provided of staff handling or taking over F2052SHs;
- To put in place a system for 'on-call' cover by governor grades for the weekends;
- To establish a Liaison Officer for deaths in custody;
- To appoint specific staff representing different areas to attend suicide prevention management team meetings.

It is self-evident, however, that Ms Draper's recommendations in relation to D's attempted suicide were not included in this action plan, and I have not found any evidence that a separate action plan was drawn up.

10.4 Commenting on the lack of contemporaneous formal action plans, Mr Davies noted at the hearing that “formal is a big word”. He said the recommendations related solely to compliance with the Prison Service Order and that an audit had shown the prison was performing well in this respect. He suggested that the weaknesses as identified were lapses, so the recommendations meant in effect not to have any lapses. As such, they were not much use. He said it was exactly in the high risk places that lapses would occur. Minor lapses would be highlighted by any investigation and criticism would always arise from the F2052SH. He added, “Opportunity to fail in a system such as this is quite high.”

10.5 Mr Davies said implementation of recommendations was a matter for the Deputy Governor (who was chair of the Suicide Prevention Team). He could not explain why the D recommendations were not reflected in the action plan. He added that he would not have accepted all of them – for example, those relating to referrals and to looking elsewhere for best practice (when Pentonville was recognised as leading the way). He said recommendations were recommendations – not instructions. He would have discussed them with the Area Manager (no formal record was kept of discussions, but the Area Manager’s notes of his visit might refer). Mr Davies emphasised that it was very unusual for all recommendations to be accepted; what was logical to an investigation might not make sense for the establishment concerned.

10.6 He added that the process for actioning plans varied. Where the need for action was identified immediately, it would have been taken before the investigation. The remainder flowed from the recommendations themselves (and acceptance of the recommendations). He and the relevant functional head would discuss the prison’s response. If there was a perfectly good policy worked out and codified, he would identify from any audit that the prison was compliant. He said he had evidence that the prison was compliant because they had again achieved a ‘double good’ in 2004, and was “pretty convinced” from the audit report and his own audit procedures.

10.7 Mr Davies said an action plan would not make multi-disciplinary case reviews any more practicable. This was not defeatism, merely a reasoned response. It was not the case that there were no reviews. He had continually pointed out the impracticability of multi-disciplinary case reviews, but no-one had responded helpfully.

10.8 A table setting out action taken in the areas highlighted by Ms Draper was produced at some time during the D court proceedings. Under a column entitled ‘Implementation’ was written:

- 8.1 Implemented post 2002.
- 8.2 Implemented after system review in 2003. See PSO 2700 (issued 4/11/2002) Annex B F2052SH procedures on case reviews and support plan and Section 3 of Suicide Prevention Strategies Booklet issued 1/1/2003 (which consolidated existing policy and practice) in relation to case reviews.

- 8.3 Implemented after system review in 2003. See also PSO 2700 Annex A areas to be covered by local suicide and self-harm prevention strategy at paragraph 11.
- 8.4 Not implemented but the national standard was amended in 2002 to five irregular watches within an hour (see PSO 2700 paragraph 4.2.1).
- 8.5 Anti-suicide boxes and anti-ligature scissors were in place by 2002. See also PSO 2700 Annex D in relation to emergency equipment.
- 8.6 This was a national standard. See also PSO 2700 Annex A at paragraph 17 on staff awareness procedures. The intermittent watch has since been amended to five irregular watches within an hour.
- 8.7 This is a recommendation to follow a national standard. See PSO 2700 paragraphs 3.3 and 3.4.3.
- 8.8 This is a recommendation to follow a national standard. See PSO 2700 paragraphs 3.5.1 and 3.5.2.
- 8.9 Agency staff would be offered post incident care (see 8.8 above)
- 8.10 Implemented. See also Section 6 of Suicide Prevention Strategies Booklet issued 1/1/2003 in relation to staff training.
- 8.11 Implemented.

10.9 Mr Davies noted that the action plan produced for the Judicial Review referred to some recommendations having been implemented when in fact things had already been in place. He added that there had been seismic changes in practice since the NHS took over healthcare, meaning that the ground on which the recommendations had been made had shifted. He asked what the point was of pursuing the detail.

Consideration

10.10 I am concerned that the suicide prevention team did not discuss D's attempted suicide in an attempt to learn lessons, and I have found no evidence that any action was taken specifically in relation to Ms Draper's recommendations. This is very disappointing. It suggests an element of complacency and a lack of rigour.

10.11 I have some sympathy for Mr Davies' point about recommendations that effectively say staff should avoid lapses. In addition, the hearing heard evidence that procedures were regularly monitored (this is of course the means by which lapses are discovered and rectified). I am also mindful of Mr Davies' evidence that audits showed a high level of compliance with national procedures in relation to suicide prevention policy.

10.12 However, Ms Draper's recommendations in relation to D were not of the 'motherhood and apple pie' kind. She addressed a number of quite specific identified shortcomings – none of which, as it happens, was about staff not doing their jobs properly. Some of her recommendations were about tightening up procedures (and there can be no harm in that) and some had the potential to make a real difference at Pentonville or more widely. D's

attempted suicide and Ms Draper's unwonted (at that time) review gave the prison a real opportunity to scrutinise and improve its procedures. It did not take it.

10.13 However, I note that the prison is able to report that all Ms Draper's recommendations have now been implemented (albeit not as a direct result of her having made them¹¹⁹).

10.14 My own work on investigating fatal incidents has demonstrated over and over the value of a rigorous assessment of what went right and what went wrong. I have made very many recommendations as a result. Nevertheless, I have long been struck by the potential for learning even more through investigation of incidents of serious self-harm and attempted suicide. Apart from the lessons from the very fact that the prisoner's action was not fatal, there is the huge benefit (in many cases) of being able to talk to the prisoner directly to find out what interventions might have made a difference.

10.15 The developing jurisprudence on Article 2 of the European Convention on Human Rights is driving the Prison Service towards independent investigation of all such incidents. Clearly, this has serious cost implications and I judge that it is right that the Prison Service should seek to establish thresholds. However, the general principle of independent investigation is one I welcome. It offers further opportunities to improve procedures and practice and offers families (and the prisoners themselves) insight into what has happened.

Until such time as the jurisprudence is clarified, I recommend that the Prison Service requires all prisons to carry out investigations into attempted suicides, incidents of serious self-harm and other near deaths. These should include an independent element, and engage the person who has been harmed and/or their family.

10.16 As I have reflected throughout this report, in the event Ms Draper's report and the documentation on which it drew subsequently went missing. I understand that this was because her review was not a formal investigation. As such, the storage and retention policies that apply to PSO 1300 or 1301 investigations did not come into effect (i.e. storage at the Prison Service's stores at Branston in Burton-on-Trent). In light of developing policy in this area:

I recommend that investigations into attempted suicides and serious self-harm are brought within the aegis of PSOs 1300 and 1301 to ensure paperwork is not lost in future.

¹¹⁹ I take it from the references to a review in 2003, which is in turn linked to the publication of PSO 2700 in November 2002, that the review was prompted by the national initiative rather than by the shortcomings specific to Pentonville identified by Ms Draper.

PART XI – ARTICLE 2 COMPLIANT INVESTIGATIONS

How I went about this investigation

11.1 The terms of reference for this inquiry that I have set out on p.7 followed actions by the solicitors representing D to secure, notwithstanding Ms Draper's review, an Article 2-compliant inquiry into D's attempted suicide.¹²⁰ Following a judicial review, the matter was considered by the Court of Appeal.¹²¹ Both at first instance and on appeal, the Court agreed that an Article 2-compliant investigation was warranted. I was asked to conduct the investigation.

Loss of documents

11.2 It had become apparent as early as May 2003 that D's Inmate Medical Record (IMR) had gone missing. Nor could any of his personal record (including his F2052SH) be found. During the course of the court proceedings, the Prison Service discovered some papers that shed some light on D's stay at the Pentonville. These included some incident reports and wing history sheets.

11.3 My investigation therefore began by trying to track down the missing documents and exploring how they came to be lost. When I spoke to Ms Draper, she could not shed any light on the whereabouts of the documentation on which she drew during her review, nor the interview transcripts. However, she told me that she had worked from copies of D's records (meaning that the originals remained at the prison). My colleague, Miss McMurray, visited Pentonville to search for D's core record and IMR but had no success.

11.4 Ms Draper told me that, once she had forwarded her report to the London Area Office, all the unused material was boxed up and passed to the Prison Service's Incident Management Section. She had attached the annexes to her report, and the whole document would have been passed to the Area Manager and then to the prison.

11.5 The Prison Service had reported during the course of the court proceedings its conclusion that the records must have been destroyed (in line with Prison Service policy of destroying the records of remand prisoners one year after their release). Under Prison Service national policies on document retention, if the prisoner left the prison system entirely (as D did), his records would be sent to the prison's 'dead records' department where they would be given a destroy date in accordance with PSO 9020. This date would also be

¹²⁰ What is specifically required under an Article 2-compliant investigation is a matter for the chair in each instance, but the general principles are that it must be independent, effective, reasonably prompt, include a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.

¹²¹ R(D) v Secretary of State for the Home Department [2006] EWCA Civ 143. The Prison Service did not appeal against the outcome of the Judicial Review but against the detail of what was required.

logged onto the prison database. The records would then be filed in destroy date order. Each month, files that reached their destroy date would be taken out and destroyed and their destruction logged in a log book kept for that purpose.

11.6 Miss McMurray therefore checked both Pentonville's database and the book used for recording the destruction of files. There was no mention of D on either. This suggested that the records had not been destroyed. Indeed, Miss McMurray found evidence that D's records had been given a 'destroy date' of 25 years after the date of his release (presumably because of the unusual circumstances leading to his release). A manuscript note on a letter dated January 2002 advising that the case against D was to be discontinued said, "Destroy Dec 2026. Pls file in Dead 2052." This tends to suggest that the records are still in existence somewhere. Nevertheless, a physical search of the relevant section of the 'dead records' store proved fruitless; nor was there any record of the files being removed from the store. Neither staff in the administration office nor the litigation clerk (who might most reasonably have been expected to have drawn the file) could shed any light on its whereabouts.¹²²

11.7 I asked Pentonville to carry out a further rigorous search, but nothing was found. This means that very little detailed, contemporaneous, primary evidence exists about D's behaviour and care at the prison. In addition, Pentonville was asked to provide locks bolts and bars checks for the period of D's custody, duty governor reports, and the healthcare diary (as opposed to the healthcare log) and the special cell records for the same period. None could be found. I am of course aware that the documents I sought related to events of some seven years ago (although D's own record went missing some time before I became involved), but I can only describe record storage at the prison as shambolic. It may be that arrangements are more robust now. Nevertheless, I think the following recommendation is more than warranted:

I recommend that the Governor of Pentonville reviews all record (that is, both personal and prison) storage procedures to ensure important documents are not lost and can be readily located.

11.8 Miss McMurray visited the registry at the Prison Service stores in Branston to look for any material relating to Ms Draper's review.¹²³ Happily, this resulted in the discovery of the tapes on which Ms Draper's interviews were recorded. I had these transcribed and referred to them as part of my

¹²² In the judicial review hearing Mr Justice Munby noted that, "The loss or destruction of the inmate medical records involved a clear breach of the Prison Service's own guidelines in PSO [Prison Service Order] 9020, paragraph 3.1 of which requires such records to be kept for ten years. The loss or destruction of the core record was, it might be thought, inconsistent with what is said in paragraph 3.1.3 of PSO 9020" (which specifies retention periods for documents).

¹²³ A copy of Ms Draper's report itself was apparently found 'by chance' in Safer Custody Group papers.

investigation. However, in light of the need for independent investigation, I also conducted my own interviews.¹²⁴

11.9 Miss McMurray also conducted a search at the London Area Office for the investigation papers, again without success.

Preliminary evidence gathering

11.10 At the start of the investigation, Miss McMurray and I visited HMP Pentonville to talk to the then Governor (Mr Nick Leader), to meet members of the Independent Monitoring Board, and to visit the wing and cells in which D was located during his time at the prison. We also visited the new healthcare centre. My normal practice in conducting an investigation at any prison is to meet a representative of the local branch of the Prison Officers' Association. However, despite several attempts to make contact, the POA branch declined to engage with me on this occasion.

11.11 We also met D's solicitors to discuss how the investigation would proceed.¹²⁵ I made clear my wish that the investigation should be completely open and engage them, on behalf of D, as much as possible. I undertook to disclose all evidence as I received it in order to facilitate this. I also agreed that all interviews would be tape recorded and transcripts produced, but that, for working purposes only, notes of interviews would also be produced.¹²⁶

11.12 I subsequently visited Ms Carole Draper. She was able to describe her investigative methodology, and also supplied me with manuscript notes she made at the time of her investigation. This included a manuscript record of an interview with Dr Robert Halsey.

11.13 Miss McMurray contacted HMP/YOI Feltham to find out whether any of D's records relating to previous spells in prison had been retained. They had not. In addition, Treasury Solicitors contacted several hospitals that had treated D at different times around the period in question. (The Royal Free Hospital provided copies of its own records, but did not have any Prison Service records for D. However, some of their medical notes shed light on D's medications whilst at Pentonville.) Finally, we arranged for the Police National Computer to be interrogated for information about D's self-harm at

¹²⁴ I re-interviewed, inter alia, all those interviewed by Ms Draper except for Ms Chikuku and Dr Yisa. I had understood from court papers that the former was no longer in this country. Of course, this turned out not to be true. At this point in the inquiry, Dr Yisa told me he did not wish to engage with my investigation. Again, by the time of the hearing, I am pleased to say this was not the case.

¹²⁵ I am conscious that some might perceive procedural imbalance in my consulting in this way with D's representatives, but not with those acting for the Prison Service. However, this is in line with my normal practice in fatal incident investigations and reflects my Article 2 responsibility to engage with the person concerned or his/her family.

¹²⁶ Transcripts tend not to be user-friendly in that they are extremely long and not always completely coherent. Nevertheless, while notes offering a summary of the evidence were used for reference/working purposes, in line with the agreement I made it is the signed transcripts that constitute the evidential base of this report.

court immediately before his arrival at Pentonville, but this threw up nothing of use.

11.14 From the paper records that were available from Pentonville (such as incident reports and the healthcare centre log), Miss McMurray identified a number of staff who had come into contact with D and/or played some part in his care. She interviewed a number of these, and re-interviewed those staff involved in the incident on 27 December 2001. Some were no longer employed by the Prison Service and I am grateful to them for their co-operation. She and I together interviewed Dr Halsey and the former Governor, Mr Davies. All interviewees were provided with a copy of my terms of reference and 'Notes for Interviewees' – a document setting out the purpose of the interview, what would happen to the evidence and the interviewees' right to be represented if they chose. All interviews were tape recorded and the resulting transcripts were reviewed and signed off individually.

11.15 Miss McMurray also wrote to others whose names appeared on the papers asking if they could contribute to the investigation. None could.

11.16 She obtained a number of other documents in which D was mentioned, copies of minutes of suicide prevention team meetings and related papers, a copy of a suicide prevention audit conducted in spring 2002, and reviewed policy documents in force at Pentonville in 2001. She also referred to reports of investigations into deaths at the prison in 2001 and 2002 (as well as Ms Draper's report of her review).

11.17 Finally, the Prison Service was asked to provide a range of mostly policy related material and to submit evidence on a number of issues identified as being relevant to this investigation. (Provision of this information took considerably longer than I had anticipated.)

11.18 The Prison Service also undertook in February 2007 to secure the co-operation of the former senior medical officer, Dr Yisa. Again, progress in meeting this undertaking was rather slower than I had hoped, and I came close to recommending the conversion of the investigation into an inquiry under the Inquiries Act. In the event, there was no need and Dr Yisa very helpfully contributed to the public hearing.

11.19 All evidence gathered during the course of the preliminary investigation, including transcripts of interviews, was shared with D's representatives and with the Prison Service.

Clinical review

11.20 At an early stage of the investigation, D's representatives asked me to appoint a clinical expert to the inquiry. Given the paucity of contemporaneous medical records, I declined. I considered that there was little on which such an expert could comment usefully or with any real certainty. Too much would

rely on inference and guesswork. I remain of the view that my initial assessment was not unreasonable.

11.21 Nevertheless, much later in the investigation, I agreed to D's representatives engaging Professor Paul Rogers PhD, MSc (Econ), RN, Cert ENB 650 Beh Psychotherapy, Dip Beh Psychotherapy, Professor of Forensic Nursing to provide, *pro bono*, an assessment of D's care at Pentonville. Professor Rogers submitted his report in late June 2007.

11.22 Upon receipt of the review, the Prison Service asked to be allowed to instruct its own expert to consider Professor Rogers's findings and provide a second opinion on D's clinical care. In the interests of equality and fairness, I agreed. Dr Ian Cumming MB BS MRCPsych submitted his report in early October 2007.

11.23 Both Professor Rogers and Dr Cumming contributed very significantly to the inquiry, and I now judge that it might have been better had the inquiry commissioned its own expert(s) as D's lawyers had suggested. This is an important lesson for any Article-2 compliant investigations that may take place in the future.

Hearings

11.24 Having reviewed the evidence gathered during the first stage of the investigation, I drew up a list of witnesses to give evidence at hearings. (This was – alongside my publication of relevant material on my website – to satisfy the requirement for a public element to the investigation.) This was agreed with both the Prison Service and those representing D, as were lines of questioning.

11.25 Those who gave evidence were given advance notice of areas to be covered including any criticisms likely to be levelled at them.

11.26 Hearings were held over four days between 9-12 July 2007 at the International Dispute Resolution Centre in Fleet Street. Consideration of medical evidence was held over to secure the attendance of various witnesses and to enable the Prison Service to respond to Professor Rogers' report. The further hearings were held at the same venue between 19-21 November 2007.

11.27 The hearings were recorded and simultaneously transcribed using LiveNote technology. Each of the parties opened with a formal submission, before Counsel to the inquiry put questions to witnesses on my behalf. No cross-examination of witnesses was allowed and I sought to keep proceedings as informal and inquisitorial (as opposed to adversarial) as possible. However, those representing the Prison Service and D were invited to suggest any further questions for Counsel to the inquiry to put to each witness, and to submit written closing statements. The former was an innovation developed for this investigation by Counsel themselves.

A model for the future?

11.28 The final limb of my terms of reference expressly requires me to consider the implications of this inquiry for future investigations into near suicides. To assist me in this regard, I invited the thoughts of Counsel on the extent to which this investigation could act as a model for future Article 2-compliant investigations. Mr Eadie said:

“The serious efforts made to seek to ensure that the process did not become overtly adversarial were helpful and almost entirely successful. The Prison Service believes that was a real positive.

Counsel to the Investigation plays a heavy and important part in that. The fact that he asked questions, rather than exposing witnesses to cross-examination, is a critical component in maintaining the non-adversarial position. The process of short feeding in of questions at the end of Counsel’s questioning also worked well.

This non-adversarial approach is important because it is a reflection of and should underlie the entirety of the process. The fundamental aim of the process is to ascertain so far as possible what happened and to seek to ensure that if there are lessons to be learned they are identified. It is not a civil trial, or a disciplinary process, or a vehicle for criticism. Its essential purpose is fact finding and positive rather than judgmental ... It may also be a matter that will need to be carefully addressed in setting, through terms of reference, the scope of any future similar investigations.”

I am grateful to Mr Eadie for his comments.

11.29 My own Counsel, Mr Morton, also offered some extremely helpful insights. I set them out in full below:

“(a) *Documentation and Hearing Bundles*

The papers were prepared for the hearing in accordance with my advice.¹²⁷ The end result was that the hearing bundles ran to ten lever arch files (excluding witness statements and experts’ report). The extent to which these were referred to in the course of the public hearings was limited. Nevertheless the bundles had to be copied and read. On reflection, it seems to me that for the future Counsel to the Investigation in consultation with the Interested Parties may think it appropriate to offer more robust advice with a view to restricting the documentation prepared for the public hearings to that which is absolutely necessary.

(b) *Expert evidence*

¹²⁷ I wholly endorse the general point, but Mr Morton is being unduly self-critical. The responsibility for the size of the bundles rests entirely with me as chair of the inquiry.

My view at the outset was that expert evidence was not reasonably required. In the event expert evidence was adduced by both the Interested Parties. There can be no doubt that both Professor Rogers and Dr Cumming have provided the Investigation with valuable evidence, both written and oral. I agree with the suggestion made by the Prison Service that the need for expert evidence in any future inquiry should be considered on a case by case basis. There should be no presumption in favour of expert evidence. However, where a need for such evidence is identified, the Chairman should consider adopting the approach initially suggested by D's representatives of himself instructing a single expert.

(c) *Questioning from Counsel to the Investigation*

I sense that the procedure adopted for examining witnesses is generally thought to have worked well. By and large it served to ensure that the hearings did not become adversarial, as frequently occurs at inquests. However, the overriding consideration must be to ensure that the relevant facts are fully and fairly investigated. It seems to me, therefore, that questioning by Counsel to the Investigation should not be seen as a means of ensuring such proceedings will never become adversarial. There may be occasions when that is unavoidable.

(d) *Purpose of Closing Submissions from Counsel to the Investigation*

Consideration should be given as to the purpose, if any, of closing submissions from Counsel to the Investigation. I have taken the view that it is not my function to contend for or suggest any particular findings of fact or to perform an assessment of the evidence. However, if that is the correct view it necessarily means that these submissions are of limited value."

I am grateful to Mr Morton for his observations.

11.30 As I have indicated in my foreword to this report, I have misgivings about some aspects of my investigation, most notably in relation to cost and delay. However, I am pleased that for the most part we achieved a non-adversarial approach throughout. (To put the point more positively, it was an inquiry conducted by an Ombudsman in a manner consonant with an Ombudsman's approach to dispute resolution.) For this I am grateful to colleagues from all parties; without their co-operation, it would not have been possible.

11.31 I am particularly proud of the conduct of the hearings themselves. They were entirely non-adversarial. Again, I must thank colleagues for their part in this. I particularly commend the practice whereby Counsel for the

inquiry asks all the questions, agreeing with Counsel for the other parties outside the hearing room any additional matters that he will then put to witnesses.

I commend the non-adversarial approach in general, and the manner in which questioning was conducted at the hearings in particular, as a model for future Article 2-compliant investigations. The Secretary of State for Justice may wish to consider how best that conclusion can be drawn to the attention of the legal profession.

11.32 The only other point I would like to make in relation to the conduct of the investigation is that, in the event, I did not judge it necessary to request its conversion to a statutory inquiry under the Inquiries Act. I was conscious that Mr Justice Keith had not found it necessary to request conversion of the Mubarek Inquiry (notwithstanding that a number of minor witnesses declined to assist him). Nevertheless, I would not want it to be thought that conversion may not be necessary in future Article-2 compliant investigations. Indeed, a case could be made for saying that to meet the Article 2 criterion of 'effectiveness', the Inquiries Act should routinely be invoked. And, if this is the case, it is surely much better that it should be invoked at the outset rather than half-way through the investigation. My final recommendation reflects the importance I attach to this matter.

The Secretary of State for Justice should review the application of the Inquiries Act to future Article 2-compliant investigations.

PART XII – CONCLUSIONS

12.1 Leaving to one side that an independent inquiry into a near death had no known precedent, this was an unusual investigation to conduct for two very practical reasons. It was looking at events that occurred some considerable time earlier and there were very few contemporaneous documents to which to refer. There would have been little of certainty to go on without Ms Draper's excellent report. Even so, it is clear that there remain many gaps in D's story.

12.2 It follows that any assessment of how well or how poorly D was cared for must be extremely tentative. There might be much of relevance that has not come to light.

12.3 There were undoubtedly things that could have been done better. The failure to ensure D saw a forensic psychiatrist is perhaps the most glaring of these. It is also without doubt that the healthcare wing at Pentonville in late 2001 was far from ideal for looking after those who were ill or at risk of self-harm.

12.4 However, whilst hindsight will always identify things that could and indeed should have been done differently, I am mindful of the context in which staff at Pentonville operated. I consider that, in general terms, D's care fell within the range of what was reasonable in prison healthcare at the time. In addition, whilst staff might have made different choices following the phonecall that so upset D, I cannot say that those staff concerned should be criticised for not having so.

12.5 In all the circumstances, the care of D was probably little better and little worse than was the norm in any overstretched prison healthcare centre at the end of 2001. Whether such a level of care was acceptable raises questions of criminal justice and healthcare policy far beyond the remit of this already substantial inquiry.

LIST OF RECOMMENDATIONS

- 1. I recommend that the Prison Service conducts a formal review of ACCT to ensure it remains fresh, properly implemented, and attuned to individual circumstances.**
- 2. I recommend that the Hotel 9 initiative is resurrected, properly funded, and consideration given to its introduction throughout the Prison Service.**
- 3. I recommend that all agency nurses at Pentonville are given a full induction into prison procedures and practices, particularly with regard to suicide prevention.**
- 4. I also recommend that the Governor considers whether some agency nurses should be key trained.**
- 5. I recommend that the Prison Service seeks urgently to secure forensic psychology services for Pentonville.**
- 6. Until such time as the jurisprudence is clarified, I recommend that the Prison Service requires all prisons to carry out investigations into attempted suicides, incidents of serious self-harm and other near deaths. These should include an independent element, and engage the person who has been harmed and/or their family.**
- 7. I recommend that investigations into attempted suicides and serious self-harm are brought within the aegis of PSOs 1300 and 1301 to ensure paperwork is not lost in future.**
- 8. I recommend that the Governor of Pentonville reviews all record (that is, both personal and prison) storage procedures to ensure important documents are not lost and can be readily located.**
- 9. I commend the non-adversarial approach in general, and the manner in which questioning was conducted at the hearings in particular, as a model for future Article 2-compliant investigations. The Secretary of State for Justice may wish to consider how best that conclusion can be drawn to the attention of the legal profession.**
- 10. The Secretary of State for Justice should review the application of the Inquiries Act to future Article 2-compliant investigations.**