

**IN THE MATTER OF A PUBLIC INQUIRY CONDUCTED BY THE PRISONS
AND PROBATION OMBUDSMAN**

INTO THE ATTEMPTED SUICIDE OF LD ON 27 DECEMBER 2001

AT HMP PENTONVILLE

OPENING SUBMISSIONS ON BEHALF OF LD

Introduction

1. On behalf of LD it is submitted that there are a number of serious questions which arise as to the way in which LD was treated by the staff at HMP Pentonville, and as to the operation of the systems in place at the time, which should be fully investigated and commented upon by the Prisons and Probation Ombudsman in the course of this inquiry. These are matters which may well be properly deserving of criticism, and in relation to which it is important that lessons should be learned for the protection of others in the future. The purpose of this investigation is to ensure that all the facts are carefully scrutinised, all responsible are made accountable and that lessons should be learned for the future.
2. The Inquiry now has the benefit of a report from Professor Rogers -- instructed by LD. It is regrettable that the instruction had to be by LD, and not by the Inquiry, bearing in mind that it was clear that issues arose as to the adequacy of the psychiatric care provided by the Prison Service, and as to the nature of LD's mental illness and the consequences thereof. The report is plainly highly instructive, and indicates that LD was not properly treated, and that this is likely to have made a material contribution to his serious suicide attempt and to his consequent injuries.
3. To the extent that this investigation must consider such issues, it should do so from the standpoint of November-December 2001. The lessons to be learned should be

identified by reference to the actual events, and systems actually operating, as at that time. Any criticisms or recommendations should be made on that basis, and the Inquiry should not be beguiled into refraining from expressing such views on the basis that systems have changed and improvements have apparently been introduced. Accountability requires a full and frank assessment of the circumstances as they operated in relation to LD, and analysis of the lessons to be learned therefrom.

4. Whilst it is clear that systems have altered since that time, there are simply insufficient facts before this investigation to enable any reliable view to be taken as to the effectiveness of the operation of such systems as at the present time. The reality is that the systems supposedly in place were not operating properly on the ground as at 2001. The report of an unannounced inspection by the Chief Inspector of Prisons in June 2006 (Bundle 7) show that even at that time the systems supposedly in place as at that time were not properly operating. For example, it is stated that “*the effective operation of agreed systems remained at best patchy and at worst non-existent ...*” Introduction, p.5, at p.10 it is noted that none of the 12 main recommendations had been fully achieved. Of the ten specific recommendations as regards self-harm and suicide only one had been achieved (see pp.37-42). There had been 171 self-harm incidents in the previous six months (para 3.36, p.40). Particular emphasis was made in this report upon the lack of support for prisoners (“*there continued to be too little attention to supporting prisoners during the early days.*” P.11, HP 11), effective multidisciplinary involvement (“*there was little multidisciplinary involvement in assessments and reviews*” p.11, HP 11; none of the ACCCT reviews the team looked at had been multidisciplinary, p.38), poor engagement (“*there was some poor engagement with prisoners and little focus on their needs*”, p.11, HP11), the quality of observation and recording (para 3.38, p.41 – managers checked entries were being made but not the quality, few interventions for prisoners at risk of self-harm were evidenced), a lack of recognition or investigation of near-miss incidents (there was a clear discrepancy between near misses identified by managers – none, and the statistics which showed three and four incidents where prisoners had been found hanging and had been cut free by staff and another where a prisoner had had to be taken to hospital by ambulance. None of these had been investigated), and on the

- need for officers to be required to carry ligature cutters on their belt (at p.42). All such criticisms/observations appear to apply to the situation in 2001. It is clear, therefore, that no assumptions can be made as to the reality of improvements which appear on paper, or as to the effective operation of systems which have been introduced.
5. At this stage, it is proposed to do no more than to highlight the issues as they arise, and to indicate the areas which require anxious scrutiny and at least *prima facie* indicate that all precautions reasonably available were not taken to protect LD from life threatening injuries and/or from the consequences of his attempted suicide.
 6. The report of Professor Rogers raises a number of serious issues. In particular, Professor Rogers identifies the lack of appropriate emphasis upon psychiatric care within the prison, and the consequences of a system which fails to provide proper psychiatric evaluation and care to prisoners with mental illness and/or at risk of self harm. He also raises serious questions about the recognition of LD's symptoms of mental illness and the response to his presentation. At paragraph 55 of his report Professor Rogers identifies that LD expressed a wish to die, self-harmed or attempted suicide/self-harm on at least 16 separate occasions between 29 November 2001 and 27 December 2001 (although as he properly acknowledges it is difficult to be clear as to the exact number of incidents). He includes incidents when LD informed those caring for him that he was hearing voices telling him to kill himself. This particular clinical symptom appears not to have been properly heeded. As Professor Rogers states, such auditory hallucinations should ring alarm bells for those concerned with preventing self harm and clearly indicated the possibility of a mental disorder. However, LD was not seen by a psychiatrist, his mental illness appears to have been missed by Dr Yisa (who did not have a psychiatric background and apparently identifies LD as having an emotional rather than a psychiatric problem), and was never given appropriate psychiatric treatment. Professor Rogers further identifies that whilst Dr Yisa believed that the drug which he prescribed for LD on 4 December 2001 was a tranquilizer, it was in fact an anti-psychotic (Chlorpromazine). This again raises serious concerns as to the standard of psychiatric care (if any) provided to LD.

7. LD is now permanently incapacitated and requires considerable care. His impairment is clearly permanent. This arises by reason of his serious suicide attempt on 27 December 2001. Delay in cutting him down may well have contributed to this.
8. At present the proposal appears to be for the Inquiry to be convened in two phases – with evidence of fact bearing heard first. Medical evidence will be considered after an adjournment. However, clearly the report of Professor Rogers identifies issues which must be addressed with witnesses of fact – particularly given the extent to which prison officers were making clinical judgments as to prisoners’ location, observation and healthcare needs, and were thereby performing essentially clinical roles within HMP Pentonville at the relevant time.
9. A detailed chronology has been prepared and is served together with this Written Opening. This is a detailed summary taken from the documents before the Inquiry. Save for one or two *italicised* entries it is entirely factual. Reference will be made to it during the oral opening with a view to ensuring that the relevant documentary evidence is properly taken into account at all times.
10. One final preliminary point arises. The evidence as to the delay between LD’s attempted suicide and his resuscitation is contradictory and, at present, it is not possible to know precisely what period of time elapsed during which his brain was deprived of oxygen. This is a factual matter to be investigated by the Inquiry (and by reference to the evidence of Nurse Chikuku, Officer Leane and Officer Hayward. Officer Leane at paragraph 8 of his Statement refers to it taking about 3-5 minutes for someone to locate the scissors, and this was after attempts were made to lower LD without scissors). However, in order properly to ensure that the potential responsibility for LD’s injuries is fully investigated the Inquiry is invited to commission evidence (if appropriate, in written form only) from a neurologist to ascertain the extent to which delay may have contributed to LD’s brain damage. The need for such evidence is highlighted by the evidence of Officer Hayward that delay is obviously critical in terms of injury. Whilst obviously it is commendable that LD’s

life was saved, that should not divert attention from the contribution which delay may have made to his permanent and incapacitating injuries.

The system in place at HMP Pentonville

11. In the period leading up to December 2001 there had been many openly expressed criticisms of the provision for healthcare at HMP Pentonville. In material respects these defects had not been remedied before December 2001 (eg HMCIP report 1999 – healthcare is a disgrace (p.3), Board of Visitors Annual Report 2001). There was also a failure to comply with recommendations at a central level as to prevention of suicide (eg Suicide is Everybody’s Concern – May 1999 & Health Care Needs Assessment 1999-2000). Earlier standing orders also identified particular needs in relation to suicide prevention and the management of prisoners at risk. By way of example, Standing Order 13 April 1991, identified the need for frequent attendance by medical officer when prisoner is under special supervision (para 32), the requirement of communication with medical officer before unfavourable news communicated (para 33), and a system of recommendations for transfer for psychiatric evaluation (para 55).

12. Careful review of the evidence now before this Inquiry (in written form) indicates that there appear to be a number of areas in which the system failed to take all reasonable precautions against the risk of suicide or serious self harm by those imprisoned in HMP Pentonville. These apparent failures must be viewed in the context of a known serious problem of suicide and self-harm in custody, an awareness of the importance of providing health care to the standard that would have been available in the National Health Service, clear identification at a central level of the importance of recognising and taking meaningful steps in relation to the risk of self-harm, and a physical environment which was clearly poor, and had previously been the subject of criticism.

13. It is also clear that there were a high number of serious self harm incidents around the time of LD’s serious suicide attempt. Mr AD had made a serious suicide attempt and subsequently died shortly before LD’s incident, as did Mr M. Mr C died the day after

LD, not as a result of committing suicide or attempting self harm. Further incidents were investigated in 2002. There also appears to have been a further incident of attempted suicide on the 27 December 2001, and a further incident was investigated by Ms Draper in 2002. This presents a worrying picture and is indicative of the potential consequences of the sorts of failures which appear to have arisen in the implementation of systems of providing care to vulnerable prisoners in HMP Pentonville.

Issues to be Addressed by the Inquiry as to the System in Place at the Relevant Time

14. The following issues give rise to questions as to accountability and responsibility which must be carefully scrutinized by this Inquiry:

- a. **Screening at reception** - The lack of psychiatric involvement, and reference to all available information, on screening at reception. This is problematic given the extent to which this represents a critical period for risk assessment and care planning, and the vulnerability of prisoners (particular those in prison for the first time) upon reception into prison. There appears to have been no attempt to ensure that all previous information known about LD was taken into account in assessing LD's risk (as per the details set out in the inmate information system) and no attempt appears to have been made to consider accessing information from outside the prison itself (save in respect of the PER).
- b. **Communication and use and availability of records**- The lack of clear communication of important medical information relating to the psychiatric vulnerability of a prisoner to those who are assessing prisoners on reception, and onwards with the patient onto his allocated accommodation (whether healthcare or on the ordinary wing). Indeed, the lack of communication and unreliability of available records is a key theme affecting LD throughout his stay in IIMP Pentonville in November-December 2001. It taints nearly all aspects of LD's care. The lack of auditable records of handovers leaves the issue of communication between members of staff, including between prison and healthcare staff, shrouded in mystery. Of particular concern is the lack of available information for

- assessments by the visiting psychologist Mr Halsey, the unreliability of the register of the F2052SH, and the lack of communication to Agency Nurse Chikuku on 27 December 2001 of the need for particular vigilance with LD and why. Further, even allowing for the disappearance of many documents, the records in general are such that it is highly unlikely that anyone would be in any position to give a meaningful assessment of the vulnerability of any particular prisoner.
- c. **Care Planning** - The lack of clear communication of a care plan upon a prisoner being identified at reception as being at risk, and the lack of ongoing effective care planning. By way of example, Officer Leane's evidence is that he was not aware of any care plan for LD.
- d. **Allocation Decisions** - The lack of clarity and structure as to decisions as to allocation, and the apparent lack of clinical psychiatric involvement in this decision. Given the potential vulnerability of prisoners and the high degree of mental illness in the prisoner population, this is a crucial decision and one in which clarity and clinical involvement are, or may in appropriate cases be, essential. There was uncertainty as to the use of safer cells – the evidence shows confusion as to whether these were for protection or punishment, and as to who had the authority to place a prisoner in such a cell, and in what circumstances. There is also a lack of clarity as to the use of wards as opposed to single cells in healthcare. The use of a ward may have enabled greater socialisation, yet it is clear that the prison staff were anxious to move away from wards. It is not clear that proper clinical input was sought as to the arrangement of the healthcare facility, or as to the appropriateness of wards being used in relation to patients who required observation and for whom engagement was required.
- e. **Observation decisions** – there is conflicting evidence as to who was responsible for decisions as to observation, and who had the authority to make or change such decisions.

f. **Culture** - In general terms, there was a culture at HMP Pentonville of utilising prison officers rather than those with clinical training in the observation and care of those with mental illness. Whilst this may have value from the point of view of discipline and order, it evinces a lack of respect for clinical principles, and minimised the scope for clinical therapeutic input in such matters as assessment of prisoners, allocation decisions, use of safer cells, undertaking observations, and monitoring risk. To cite one example, observation of those with mental illness should involve a process of ongoing interaction and assessment, however, this requires clinical skills and training. Use of prison officers for such tasks therefore prevented appropriate psychiatric care and monitoring. Further, the use of agency staff who did not have keys to the rooms minimised the opportunities for meaningful engagement. The problem of observing prisoners in a meaningful way when they are located in their cell is identified by Agency Nurse Chikuku. The cultural emphasis upon discipline rather than clinical care is also reflected in an attitude of considering self harm as indicative of attention seeking rather than psychiatric vulnerability, and of not paying sufficient heed to possible indications of mental illness such as hearing voices. There was also a clear desire to keep prisoners out of the healthcare facility if at all possible. The evidence discloses that the reducing numbers in healthcare was a source of some pride, but the risk that this may leave a prisoner without proper clinical care and assessment does not appear to have been given sufficient attention. Al paragraph 73 of his report Professor Rogers states: *It is my opinion 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.*

g. **Continuity of Care** - Issues also arise as to continuity of care and the ability for a prisoner with psychiatric illness to maintain an ongoing relationship with any particular group of staff, given the use of agency staff and transfer of prisoners between different locations. This also has implications for assessment and review of prisoners as this is clearly better performed by those with an ongoing relationship with the prisoner.

- h. **Referrals** - The use of psychiatrists from the North London Forensic Service was clearly desirable, however the extent to which they could have meaningful impact upon the care of prisoners with mental illness depended upon the efficacy of the system of referrals, the availability of reliable medical and other records, the suitability of the environment in which prisoners were seen, and the ease of access to helpful input from staff with actual knowledge of the prisoner and the potential manifestations of his condition. All these appear to have been lacking. It is not clear how, if at all, psychiatric input was accessed in urgent cases. What is clear, however, is that LD was not seen by a psychiatrist notwithstanding that his was an urgent, and repeated, referral. Also LD was referred for Chaplain, listeners and Samaritans but never saw them.
- i. **Training** - Mental health and suicide awareness training appears to be hit and miss. This is of particular concern given the extensive reliance upon non-clinical staff to monitor and observe, and indeed care for, the large proportion of prisoners with mental illness. Further, training in relation to F2052SH forms appears to have focussed upon completion of the form rather than principles to apply to the care of those who are or may be vulnerable to self harm. Given the centrality of this form to the system of caring for those at risk of self harm, this is of critical importance. It is also of some concern that the Senior Medical Officer was not psychiatrically trained when it is said that 80% of healthcare patients had some form of mental illness.
- j. **Suicide Prevention Committee** - The minutes of the Suicide Prevention Committee reveal a lack of any real effort to assess actual incidents of self harm and to learn lessons. There is no reference in these minutes to the incident involving LD, or to any analysis of the other incidents which occurred prior to or after his serious attempted suicide. This is illustrative of a lack of real and effective steps being taken in relation to suicide prevention despite a system, on paper, appearing to be in place, and no real attempt to learn lessons from incidents such as that involving LD.

k. **The Daily Regime** - The reality of the daily regime for prisoners whether on healthcare or on the wing is not clear. There is conflicting evidence as to the number of hours spent in cells. Carole Draper refers to a 23 hour bang up over the Christmas period.

l. **Response Team** - The lack of availability of keys for agency staff, and uncertainty as to where or how to find anti ligature scissors is apparent from the evidence.

LD's Personal Circumstances and his Treatment at HMP Pentonville

15. LD's personal circumstances were far from favourable. His girlfriend was pregnant by his best friend. He was aware that there was a very real possibility that Social Services were going to take his child (with this girlfriend) into care. This was all known.

16. He had a prior history of mental illness. He had been identified as having had problems with alcohol. He had self harmed during a previous period of incarceration.

17. He clearly told staff of auditory hallucinations telling him to kill himself. He clearly communicated distress. He repeatedly talked of, prepared for, or attempted self-harm and/or suicide. There was, therefore, a background of high risk of self harm.

18. He was referred to a psychiatrist on 30 November 2001. This referral was repeated on 3 December 2001 (twice; once urgently), 4 December 2001 (urgently), and by Dr Halsey (visiting clinical psychologist) on 18 December 2001 (to be seen the next day or failing that at the earliest opportunity). He never received any psychiatric evaluation.

19. The likelihood is that if LD had had a psychiatric evaluation he would have been commenced on a clear medication regime for his psychotic symptoms, probably coupled with anti-depressive medication. A clear management plan would also probably have been put in place, in particular to support LD in the event of his daughter being taken into care.

20. However, the reality was that until the psychiatric assessment had taken place, all should have approached LD as someone who potentially was suffering from mental illness. There is no evidence that he was viewed as such, and Dr Yisa in fact describes him as not suffering from mental illness (albeit that the psychiatric assessment which was determined to be necessary had not been carried out and he was not psychiatrically qualified).
21. Further, the events of 13 December 2001 should have alerted staff to the unreliability of their own assessments of LD. In the morning he had been assessed as not depressed or suicidal but that afternoon he made a serious suicide attempt and had to be cut down.
22. Care planning was woeful (cf Suicide Prevention Team Policy Document 2001 at p.23 – need to show support plan being followed). Referrals to Chaplaincy, listeners and Samaritans did not eventuate. It is not clear to what extent the existence or content of a care plan for LD was even known. Nor is it clear what information was being relied upon by those taking decisions as to allocation, observation or management of LD in general.
23. Issues regarding his daughter being taken into care had been clearly identified. He was allowed a telephone call on 27 December 2001 in the hope that this would calm him down but no contingency plan was put in place to deal with the possibility that he would receive bad news. Officer Hayward says that "*if he had been particularly abusive or aggressive then I would have made a point of actually going out and standing there, just to sort of be made available in case anything happened.*" but did not appear to have any procedure in place to deal with the risk of self-harm.
24. There was no proper communication of the need to be vigilant following this telephone call. Agency Nurse Chikuku was not aware of the problem, or of the need for vigilance. LD remained locked in a cell on his own – and the Agency Nurse observing him was only able to do so through a locked door. Thus, at a point of high risk (identified as such) he was left in a situation of maximum vulnerability.

25. LD had kept blocking the spyhole on 27 December 2001. That was not indicated in records.
26. Further, it does not appear that any additional precautions were taken after he was identified as being at greater risk than had already been identified. It is not clear that any clinical input was sought, nor that any attempts were made to ensure that he was not in the position of highest risk, i.e. alone in his cell.
27. As set out in the chronology, there were numerous (on any view at least 12, and probably closer to 18 – depending on the characterisation) clear and explicit warning signs which showed the clear risk of self-harm/suicide presented by LD, the clear distress he was experiencing, and the need for active management of his psychiatric issues.
28. The following issues arise in relation to the response to LD's serious suicide attempt:
- a. lack of access by agency nurse;
 - b. delay in obtaining anti-ligature scissors;
 - c. delay in getting emergency bag and in accessing scissors from emergency bag;
 - d. general impression of disarray and panic, most particularly revealed in the witness statement of Officer Hayward at p.7;
 - e. Dr Khan apparently started to walk away from the scene of the resuscitation and having to be called back; and
 - f. Time is clearly significant in relation to brain damage – SO Hayward is clear as to this.
29. There was no debrief. The next suicide prevention meeting is silent as to this incident.

Conclusion

30. Whilst it is appreciated that this is an inquiry into the circumstances in which LD came seriously to harm himself on 27 December 2001, the Inquiry is respectfully invited to consider all of the matters identified above, and such further issues as may arise during the course of the oral evidence, with a view to ensuring that those responsible for LD's injuries are made accountable, and that all possible lessons are learned for the future.

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