THE INVESTIGATION INTO THE SUICIDE ATTEMPT BY D AT HMP PENTONVILLE ON 27 DECEMBER 2001

CLOSING SUBMISSIONS OF THE PRISON SERVICE

1. The Prison Service maintains and does not repeat the matters dealt with in its Opening Submissions to the Investigation – and, in particular, the points made in paragraphs 1-16 and in the oral opening submissions (9.7/63-75).

2. The focus of these submissions is on what appeared from the oral hearings to be the central issues.

The sequence of events on 27 December 2001

Events leading to the attempted suicide

3. It seems likely, although it is not entirely clear from the records that exist, that on the morning of 27 December 2001 a razor and a noose were found in D's cell. As set out in the Opening submissions (para 35) it is evident that this discovery was taken seriously – D was asked for and proferred an explanation, a record was made of both in the F2052SH, he remained on 15 minute documented watch.

4. The decision to allow D a phone call was taken by Officer Leane, after consultation with SHO Hayward, and after D had smashed his locker (it appears probably because he had not been given the phone call Officer Leane had promised him earlier in the day). They gave approval to use the office phone. The intention was to assist D, and to diffuse a potentially difficult situation (Hayward, para 51).

5. There is nothing to indicate that the officers concerned knew in advance that the call to his girlfriend would be likely to bring bad news. Officer Leane was quite clear that he did not know before the phone call about the possibility of D's child being taken into care (9.7/158), pointing out that he was initially concerned that D had been told that his child had died. SHO Hayward could not have been told of that possibility before the phone call if that is right.

6. In the event, it did so because D was told that his child had been taken into care. There is some difference of recollection between the officers involved and Nurse Chikuku as to D's emotional state after the call – see para 39 of the Opening. It seems probable, and natural, that he was upset and may well have been tearful.

7. Officer Leane took him back to his single cell. There was no association running at that time (9.7/142). He wanted to discuss/report the matter with SHO Hayward. He did not regard it as part of his role to make decisions about what steps to take in relation to D. That was both understandable and correct.

8. It is not clear whether anyone informed Nurse Chikuku about the call.

    8.1. Officer Leane cannot recollect speaking to her when he returned D to his cell; but he was "sure [he] would have" (9.7/146).

    8.2. Nurse Chikuku's recollection is that there was no such conversation.

9. There is nothing to indicate that Officer Leane, who was concerned about D, did anything other than go straight from the cell to see SHO Hayward. The recollections of timings from this point show some variance. The relevant references to the statements and earlier interviews are at Opening, para 43. In addition,

    9.1. SHO Hayward's clear recollection is that Officer Leane came to see him; they talked about D and the phone call; he decided to make and then made the entries in the F2052SH and in the observation book (staff be vigilant); and then the alarm went. "It was literally the amount of time it took for me to write in the two entries before the alarm was sounded" (12.7/88). That recollection is bolstered by what he says he would have done, if he had had the time: "certainly" gone down to see D, then looked at the appropriate level of supervision. He had authority to implement a 1 on 1 watch (12.7/105); but did not have the time to consider that.

    9.2. Officer Leane stated that he would still have been in SHO Hayward's office when the alarm was raised (Leane, para 36). He had told Ali McMurray that the period might have been longer – anything up to 30-45 minutes. But, at the hearings he acknowledged that he was not very sure on timings. There is nothing to support such a time lag; and it would be inconsistent with the evidence of SHO Hayward, and indeed his own statement.

    9.3. Nurse Chikuku could not really recollect the precise sequence at all by the time of the hearing. Her original recollection to Carole Draper was also uncertain but made reference to a period of 10 minutes. She also recollected that she saw D hanging on her **first** check of D after he returned to the cell following the phone call.

10. It is submitted that SHO Hayward's evidence on this point is convincing and represents the most likely sequence of events (12.7/86-9). Officer Leane's evidence on reflection supported it. Nurse Chikuku's evidence was consistent with it. SHO Hayward was clear as to what he would have done, appreciating, as he plainly did, that D was a source of concern after

the call. The fact that he did not have the chance to do them is powerful support for his recollection on the timings.

11. 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 10 minute reference was a maximum not an estimate – and in any event, SHO Hayward's recollection is stronger and more soundly based that hers.

12. The consequence of accepting SHO Hayward's evidence on this point is that there was in fact the most limited, if any, real time in which to have done anything differently on the day.

    12.1. The decision to afford a phone call was a reasonable, sensible and supportive one.

    12.2. There is no basis for finding that anyone knew about the possibility of D's child going into care.

    12.3. Officer Leane reacted appropriately after the call. He wanted to bring matters to SHO Hayward's attention for him to decide what to do. There was no association – so that was not an option. Officer Leane was not the appropriate person to make decisions about relocating D (eg to the ward). So a return to the cell was the only appropriate option. Nor was he the appropriate person to consider a change in watch from 15 minutes – that again was a matter for SHO Hayward to consider.

    12.4. It would be difficult indeed to criticize Officer Leane for not alerting Nurse Chikuku to the call before going to see SHO 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.

    12.5. SHO Hayward was clear that all of these matters would have been considered by him – once he had had a chance to go and talk to D. But he did not have that opportunity.

13. In short, the submissions and analysis of the relevant sequence of events leading to the attempted suicide as set out in paragraphs 36-53 of the Opening are maintained. For the additional reasons set out above, it is now clear that the SHO Hayward sequence is likely to have been the correct one.

The saving of D's life

14. The evidence at the hearings fully supported the position set out in paragraphs 54-57 of the Opening.

15. There was an initial difficulty in getting the anti-ligature scissors; and SHO Hayward was frustrated by the fact that the nurse who went to get the emergency bag had simply thrown the bag into the cell. However, on the evidence, there was no substantial delay as a result.

    15.1. SHO Hayward put the period from the time he arrived in the cell to the time when the scissors arrived as being 20-30 seconds (12.7/91). In his second round of questions he highlighted the existence of a number of pairs of scissors on the wing; and the fact that the emergency bag was kept only 10-15 yards from D's cell.

    15.2. Officer Richards estimated that the scissors arrived "within seconds, the first minute of us arriving there..." (10.7/87). He maintained and supported that answer in his second round of questions (10.7/112-113). He put it at "under a minute"; stated that he had never had to wait anything like 3-5 minutes in the situation of supporting a hanging person; and stated that he could not see how it could have been that long given that the scissors were in the gated cell literally yards from D's cell.

    15.3. Officer Leane having considered that the time from his arriving in the cell to the scissors arriving could have been 3-5 minutes, indicated at the hearings that "that could have been 30 seconds because...everything is going on" (9.7/149).

    15.4. It is also to be noted in this respect that D was in fact resuscitated, which is only consistent with him not having been hanging for a significant period of time.

16. Accordingly, it is 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 SHO Hayward (see Opening, paragraph 56). There can be little doubt that the efforts of SHO Hayward, Officer Leane and Officer Richards saved D's life – as the hospital acknowledged.

The management and care of D

17. A series of criticisms have been made of the management and care of D. Before turning to the major ones, it needs to be emphasized 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. Whilst unsurprisingly there may have been divergences of view as to how best to drive forward the process of change and improvement, all those who have given evidence plainly were focused on the needs of those within their care.

The changes – a positive or a negative?

18. It is submitted that, for all the reasons given by in particular Governor Davies and Mr Attard (both orally and in their statements), the changes were both necessary and successful in terms of making a significant improvement in Healthcare.

19. There seems to have been an element of tension between as it were the new and the old regimes. Dr Yisa was acknowledged by others as having considerable skills - notably in developing relationships with the psychiatric services outside HMP Pentonville. However, it may fairly be thought that he was not entirely enamoured of the new regime introduced by Gary Monaghan and John Attard, at Governor Davies direction. It may be that that in part at least explains his recollection about the shift in emphasis, as he saw it, from healthcare to discipline. However:

    19.1. The changes were prompted by the then failings in the Healthcare Centre. Governor Davies recognized the need for action and set about seeking to improve the situation. He appointed Mr Monaghan to whom John Attard reported.
    19.2. John Attard introduced a series of changes designed to improve the physical environment and the regime practices in healthcare.
    19.3. The changes do appear to have effected an improvement in Healthcare - at least, in the views of most of those involved. In particular, the introduction of additional discipline officers was positively advocated by the likes of SHO Hayward as a means of giving "some sort of stability within healthcare at that time" and to deal with the routine, but necessary jobs that healthcare staff had not been happy to undertake up to that point (12.7/16).
    19.4. The perception of those from outside such as Dr Halsey was consistent with that of the officers and management who gave evidence: that the working relationships in Healthcare worked well. Dr Halsey described it as a "reasonably good relationship - there is a lot of stress, very difficult working conditions, but all things considered I think people treated each other with respect and the relationships were functional" (20.11/121).

20. Staffing levels and/or the staffing mix were perceived by Dr Yisa to be a problem. Opportunistically, Prof Rogers' supplementary report sought to build on this. However,

    20.1. 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 the 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.

20.2. John Attard's belief was that, with the introduction of the specially selected discipline officers, the number of staff working in the healthcare centre actually increased (12.7/126). It is also clear from his evidence that much time and trouble was spent seeking to ensure the most efficient and effective make up of staff (see eg 12.7/124-34). His belief was also that staffing levels were not lower than elsewhere in the prison service, that there was a high staff to prisoner ratio; and that there was a good mix of staff: see paras 37-41 of his statement at Bundle 3, Tab 9.

20.3. In the absence of full staff figures, it is hard to be clear on whether there were shortages and if so, for what periods. However, it appears that there were significant numbers of healthcare and nursing staff available: see eg SHO Hayward at 12.7/7. In addition, there is an important piece of directly relevant evidence contained in Bundle 1/1 at p 10 (explained by Dr Ranaweera at 20.11/90-1). This shows that, on 27 December 2001, there were a number of qualified psychiatric nurses on R1.

20.4. At from April 2001 a senior, and much praised, matron was in place as a new appointment: Kay George (see eg Attard on 12.7/131).

20.5. Finally, the systems in place to ensure the provision of appropriate, and appropriately informed, care included an allocated doctor for each prisoner in Healthcare – in D's case, Dr Ranaweera.

Psychiatric referrals

21. The basic facts as they appear from the documents that survive are set out at Opening, paragraph 75.

22. The Opening at paragraph 72 stated positively that D was not seen by a psychiatrist despite having been referred to one on a number of occasions. It is submitted in the light of the evidence of Dr Ranaweera and Dr Yisa that that is far from clear. There are essentially two alternatives: either a records loss/failure or a breakdown in the system for ensuring that referred patients were in fact seen.

23. The position as it emerged from the evidence was as follows:

23.1. There was good access to psychiatrists at the time in Pentonville, with psychiatrists in the prison on a daily basis (see Dr Yisa at 19.11/73). Indeed Dr Yisa considered that a prisoner would have got to see a psychiatrist more quickly from inside than outside prison (19.11/74). There was therefore not simply "equivalence" in this area (and indeed in access to psychologists such as Dr Halsey) – prisoners had readier access to this specialism than those in the community. Dr Ranaweera pointed out that D Hadjiof and Dr Hurst "were available most of the week, most of the days" (20.11/85).

23.2. 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. That system comprised both an initial layer for ensuring that they were seen by the named psychiatrist; but also a fall-back or safety net system for ensuring that, if not so seen, they would be seen by another visiting psychiatrist. The system is described by Dr Ranaweera in her statement and in her evidence at the hearing (20.11/57 et seq). It is to be noted in relation to the system that the system had not yet changed by the time of D's attempted suicide. Dr Halsey stated to Carole Draper that the referral system involving Tony Madden and the in reach team was not in place at the time of D's attempted suicide: Bundle 2, page 119

23.3. There were also (a) daily ward rounds undertaken by the inpatient doctors in healthcare (Bundle 13, Tab 3, para 9); (b) twice weekly case conferences, with multi-disciplinary input, undertaken in Dr Yisa's office (Bundle 13, Tab 3, para 10); (c) more informal provision or exchanges of information as all the doctors met up over lunch in Dr Yisa's office on a daily basis.

23.4. Those on healthcare had a doctor in charge or allocated, overseeing their case. They also would have a role in picking up if someone was not seen and ensuring that that occurred whether with the nominated or another psychiatrist. Dr Ranaweera was D's doctor in charge. She was described as careful and meticulous by Dr Yisa.

24. So, 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" (20.11/84-85) – is the only sensible one on the evidence.

25. That position is consistent with and supported by the documents that emerged late on the last day (Bundle 1, Tab 13, page 7 of the additional notes). The combination of prescriptions is entirely consistent with D having been seen by a psychiatrist (see Dr Cumming at 21.11/140). Dr Yisa stated that chlorpromazine was often prescribed by many visiting psychiatrists as a major tranquiliser and sedative: Bundle 13, Tab 5, para 64.

26. The focus then shifts to records.

27. The doctors believed that the fact of a meeting with a psychiatrist would be recorded in the IMR. However, as Dr Ranaweera noted the IMR was not always available. If not available for any number of reasons, a

continuation sheet would need to be filled in. The system for managing these appears to have involved the doctor or psychiatrist concerned filling out the form, leaving it at the IMR record room where a single person was responsible for interleaving the sheet into the IMR (see Dr Ranaweera at 20.11/95-6). Dr Halsey also made reference to this system of continuation sheets, and to the problem of IMR's not being readily available (see 19.11/114 and 133-4). As he put it in his interview with Mr Shaw (Bundle 2/136: "it was often the case that medical records would go missing..."). It is accordingly more than possible that D was in fact seen by a psychiatrist but that the relevant record did not make it into the IMR.

28. It appears that Carole Draper saw what she believed was the IMR. It is not clear that that was so. It is surprising – particularly given the conclusions she then drew – that she did not seek Dr Yisa's assistance on the document she believed to be the complete IMR and on the issue whether a psychiatrist was seen. Dr Yisa did not believe that Carole Draper had the IMR when she interviewed him (his interview in effect being tacked onto the end of an interview on another case). She did not even interview Dr Ranaweera, the allocated doctor. It is of course very unfortunate that the records are now so incomplete and that that document is not available.

29. In summary, therefore it is submitted that

    29.1. The issue whether D saw a psychiatrist is not conclusively or even clearly answered by asserting that Carole Draper saw "the IMR".

    29.2. It is not clear what she saw. Moreover, even if she did see the IMR, it may be that a record of D having seen a psychiatrist had not made it into the IMR either by that stage or at all.

    29.3. There is a clear and compelling case, based on the improbability of a multiple system breakdown involving Dr Ranaweera, for concluding that D was in fact seen by a psychiatrist.

What would a psychiatrist have been likely to conclude

30. This issue has been dealt with by Dr Cummings. His report explains in detail his conclusion that he was not persuaded on the material he had seen that D suffered from mental illness; and was not for example psychotic. His diagnosis of borderline personality disorder accorded with Dr Halsey's instinct at the time (Dr Halsey 20.11/129). This is important because there appear to be a number of suggestions by D's representatives (and by Prof Rogers, although he is not qualified to offer any such diagnosis) 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 emphasized by Dr Cumming), does not bear this out.

The various criticisms of his healthcare

31. Four matters are emphasized at the outset.

32. First, hindsight must be excluded. It is all too easy to slip into the unfair trap of tracking backwards from the attempted suicide and/or assuming that certain matters that were far from clear at the time should have been acted on.

33. Secondly, it is important to retain a sense of both realism and context before passing judgement on the actions of those responsible for D's care at the time. It is submitted that much of Prof Rogers evidence paid insufficient regard to the prison setting in which the care issues arose. Dr Cumming was clear that the prison setting is an important factor and provides a very different backdrop than would be the case in the community. 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.

34. Dr Cummings was, and it is submitted rightly was, scathing about the suggestions by Prof Rogers of equivalence: see paras 126-132 of Dr Cumming's report). It is particularly to be noted, in considering the views of Dr Cumming and Prof Rogers, that:

    34.1. Prof Rogers had only peripheral experience of working in prisons. He had had a short period of involvement on an oversight basis at HMP Parc (not working even there full time).

    34.2. The Practice guidance appended to Prof Rogers Supplementary report on which he had placed heavy reliance in fact had no status in the prison system. It was issued to NHS trusts - and Prof Rogers did not even know if it had been issued within prisons (21.11/89-90).

    34.3. Dr Cumming has had many years of practical, hands on experience working full time in a prison - HMP Belmarsh.

35. In those circumstances, it is submitted that the judgements set out in Dr Cumming's report are a far surer, sounder and more realistic basis for conclusions as to the general care and management of D.

36. Thirdly, it is important to be clear about where the care and management issues lead. Ultimately, the issues funnel down to the events on 27 December 2001. At that stage, for all the reasons set out above 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 SHO Hayward being an eminently reasonable one)? Was there time to implement any different plan thereafter (no - if SHO Hayward's evidence is accepted, which it should be for the reasons set out above).

37. Fourthly, the issue however should not be whether decisions and judgements made were "right" or "wrong". It should be whether the decisions made were within a reasonable range (excluding hindsight). Particular caution is needed before concluding that any decision was not, and before concluding that an action should have been taken and was not, given the fact that the core medical record (the IMR) is missing.

38. It is submitted that, as far as can be told from the documents that remain and the recollections of those involved, the care and management of D generally was appropriate to his needs for the detailed reasons set out in Dr Cumming's report. The following particular matters are relied on:

    38.1. D was and remained in Healthcare on open F2052SH throughout his time at Pentonville.

    38.2. It was recognized by all concerned on Healthcare that D was vulnerable. He had a history of self-harm and his behaviour, particularly in the early period of his time at Pentonville indicated a clear basis for concerns about self-harm and a possible suicide attempt.

    38.3. He was dealt with on that basis. So, for example, a F2052SH was opened and maintained throughout. His case was allocated to Dr Ranaweera who had oversight of it throughout. On various occasions, his location and his level of watch was varied to take account of what were judged to be varying degrees of risk. This is not a case in which a series of warning signs were simply missed.

    38.4. The Investigation is invited to have particular regard to the careful analysis of the various events and the reaction of Healthcare staff to them set out in Dr Cumming's report. That illustrates that a legitimate and reasonable series of judgements were made as to the care and management of D over his period in Healthcare.

39. Dr Cumming rightly emphasized that there was considerable expertise in Healthcare (see eg para 40 et seq of his report). 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:

39.1. Dr Yisa, although not psychiatrically qualified, had considerable interest in and experience of cases in which a prisoner exhibited signs of mental disorder.

39.2. Healthcare had a number of psychiatric nurses working in it (as appears from the 27.12.01 rota and Bundle 1/1).

39.3. D was seen (at least) by a psychologist. His conclusion, entirely consistent with the opinion of Dr Cumming, was that he was not mentally ill but was suffering from a personality disorder.

39.4. The diagnosis, on the evidence before the Investigation, is not one of mental illness. So, the care and treatment would have been highly unlikely to have been materially different – including the medication (see further below).

39.5. Dr Cumming rightly concluded that "overall, in [his] opinion, a psychiatric assessment would have made limited impact upon D in either his overall care but also in preventing the incident that took place on 27.12.01" (para 124 of his report).

40. Criticism was initially made by Prof Rogers of medication that D was prescribed. There is no basis for any such criticism. Not merely did Dr Cummings opine that the medication was entirely appropriate; but the combination of drugs prescribed appears consistent with D having in fact been seen by a psychiatrist.

41. Criticism is made of the information flows and in particular the handovers. No doubt the information management systems were not ideal (they have now been transformed). However,

41.1. There were handovers between shifts, which were a valuable means of ensuring that important information was passed on to the incoming shift.

41.2. The F2052SH and the observation book were available for all concerned to the extent that the major issues had not been dealt with in the handover.

41.3. There was a system of allocated doctors. That system ensured that each patient's case was overseen and known in detail by a doctor.

41.4. Daily ward rounds and twice weekly, multi-disciplinary case conferences occurred to discuss the case and make decisions about appropriate care, in addition to the more informal exchanges of information between doctors.

41.5. There is no reason to conclude that such plans as were considered appropriate (including nursing care plans) were not drawn up and adhered to. The IMR, where the detailed records would have been made, is of course no longer available.

42. Some time was spent examining aspects of reports in other cases. The points made in opening are repeated with particular emphasis in closing. Very considerable caution needs to be exercised before seeking to draw analogies or parallels between other cases and D's case, and before seeking to rely on other cases as a basis for concluding that a particular practice was widespread, common or systemic. The Investigation has not gone into the facts of those cases in any detail; and detailed submissions have not been made about them. Superficial or apparent similarities are likely at best to be precisely that.

Conclusion

43. In all the circumstances, it is submitted that

    43.1. although there may be areas to be highlighted for improvement or change, there is no real basis for criticism of those responsible for D's care at Pentonville;

    43.2. there are, by contrast, some aspects to be commended, notably in the prompt and professional reaction of SHO Hayward and his team when the emergency arose on 27 December 2001.

44. It is also important to bear clearly in mind the significant changes in the provision of healthcare at Pentonville. Both the physical environment, and the policy and practice have been fundamentally altered since 2001.

45. Finally, some thoughts on the process (with the obvious caveats that this is the first Article 2 type investigation of its kind and the lessons to be learned from it generally will need to be carefully considered):

    45.1. 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 believe that was a real positive.

    45.2. Counsel to the Investigation plays a heavy and important part in that. The fact that he asked the 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.

    45.3. 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 criticisms. Its essential purpose is fact finding and positive rather than judgmental. That will no doubt be reflected in the Report produced by the investigation. 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.

45.4. It is not clear whether the process of interviews by the investigation was either a useful or proportionate one; and there is real potential for unfairness in putting those involved through a succession of interviews about the same events. There had been some interviews already carried out by Carole Draper. The preparation of witness statements plus questioning at the hearings should be sufficient in any future case.

45.5. There is some concern about expert evidence. It may be thought to have been of assistance in this case, in which case so be it. However, the risk with expert evidence being admitted is that the process starts very closely to resemble civil proceedings for negligence (particularly it may be said if the questions posed are as they were posed to Prof Rogers). No hard and fast rules can be set for all future and similar investigations. However, there may be a considerable amount to be said for (a) considering with particular care whether any expert evidence is truly necessary or appropriate; and (b) if so, instructing a single expert, with the relevant issues being framed ultimately by the investigation itself.

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