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

CLOSING SUBMISSIONS ON BEHALF OF LD

Introduction

1. These Closing Submissions should be read together with, rather than in replacement for, the Opening Submissions served on behalf of LD. They should also be read together with the attached Chronology which contains a detailed analysis of the factual material before the Inquiry.

2. As a matter of generality, the Inquiry is invited to place more weight on contemporaneous accounts of the various individuals involved, as given to Carole Draper and in contemporaneous documentation (such as the Prison Service has retained), than on accounts given 5-6 years after the events leading to LD's injuries.

3. The Inquiry is intended to fulfil the State's obligations under Article 2 of the European Convention on Human Rights. To that end, the Inquiry must reach a view on questions of accountability, responsibility of the State or any agents of the State for the injuries sustained by LD on 27 December 2001, and in turn, on the causation of LD's injuries. Given that the aim is in part that lessons be learned, the Inquiry is able to avail itself of the benefit of hindsight.

4. As regards the substantive obligations in Article 2, the Inquiry is reminded of the following principles from paragraph 75 of the judgment of the Court of Appeal in *Van Colle v. Chief Constable of Hertfordshire Police* [2007] EWCA Civ 325:

v) Where it is the conduct of the state authorities which has itself exposed an individual to the risk to his life, including for example where the individual is in a special category of vulnerable persons, or of persons required by the state to perform certain duties on its behalf which may expose them to risk, and who is therefore entitled to expect a reasonable level of protection as a result, the Osman threshold of a real and immediate risk in such circumstances is too high. If there is a risk on the facts, then it is a real risk, and "immediate" can mean just that the risk is present and continuing at the material time, depending on the circumstances. If a risk to the life of such an individual is established, the Court should therefore apply principles of common sense and common humanity in determining whether, in the particular factual circumstances of each case, the threshold of risk has been crossed for the positive obligation in Article 2 to protect life to be engaged.

vi) Whether the obligation arose in any particular case and whether the state authorities were in breach of that obligation will therefore depend not only upon the nature of the threat and the degree of risk to the individual, of which the authorities knew or ought to have known, but also upon the extent to which there were appropriate measures, reasonably available to the authorities, to alleviate or obviate that risk. The greater the failure to take such measures as were reasonably open to them to alleviate a risk to human life, the greater the likelihood that the authorities will be held to have failed to comply with their Article 2 obligation.

5. A similar formulation was approved by Lord Carswell in the House of Lord in *In re Officer L (Respondent) (Northern Ireland)* [2007] UKHL 36, [2007] 1 WLR 2135 at [20], approving the test as stated by Weatherup J [2004] NIQB 67:

   "… a real risk is one that is objectively justified and an immediate risk is one that is present and continuing."

6. It is also clear that these principles apply as regards breach of the substantive obligation owed under Article 2 to prisoners who are in need of medical attention whilst in state custody (or indeed those compulsorily detained in civilian hospitals) – *Savage v. South Essex Partnership NHS Trust* [2007] EWCA Civ 1375 at [25] and [29] & *Tarariyeva v Russia*, application no 4353/03, 14 December 2006.

7. In *Savage* at [40] the appropriate test was held to be: *"In order to establish a breach of article 2, on the assumed facts the appellant must show that at the material time the Trust knew or ought to have known of the existence of a real and immediate risk to the life of Mrs Savage from self-harm and that it failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk."*

8. Further, at paragraph 83 of *Van Colle*, the Court of Appeal held that the test for causation under Article 2 is not the but for test, but whether or not identified steps would have had a real prospect of altering the outcome.

9. Under Article 2, the onus of providing a convincing explanation for the injuries sustained by LD is upon the State. In those circumstances, the State cannot rely upon the lack of available medical and other records to establish its case. It is for the State to produce evidence to show that appropriate steps were taken. This is of particular significance as regards the lack of any evidence to establish that LD was seen by a psychiatrist prior to his injuries on 27 December 2001. In this regard, the evidence strongly supports the conclusion that LD was never seen by a visiting forensic psychiatrist, and had no proper medical involvement between 18 and 27 December 2001. This complete lack of proper medical attention in the period up to his attempted suicide has never been adequately explained:

    a. At para 2.11: LD was referred on numerous occasions but only saw the visiting psychologist once on 18 December and never saw a visiting psychiatrist.

    b. That some of the documented 15 minute watch sheets were lost but otherwise appeared to have the IMR (at para 2.11 and by reference to the details referred to in the report).

    c. Dr Ranaweera said that if a prisoner had been seen by a visiting psychiatrist that would always be documented in the IMR (day 6, p.82).

    d. At para 6.10.1, Carole Draper notes that LD there was no entry in LD's IMR to indicate that he had seen a doctor from 18 – 27 December 2001.

    e. At para 7.1.1 Carole Draper notes that despite a number of referrals, the only visiting attendance was by Dr Halsey.

    f. No proper conclusion can be drawn from the possibility of medication having been prescribed to LD whilst in HMP Pentonville. As Professor Rogers and Dr Cummings both said, that sort of medication may well have been prescribed by a

GP (day 7, pp.50, 124 & 140). Moreover, the reference to LD awaiting a psychiatric opinion is also consistent with him not having been seen by the psychiatrist despite repeated referrals.

10. As a matter of generality, it is clear that the Inquiry has been greatly assisted by the expert evidence of Professor Rogers, and Dr Cummings. Professor Rogers in particular gave cogent and considered evidence, well supported by research and scientific literature, on the subject of psychiatric nursing and appropriate management of those at risk both in a prison, and a healthcare environment.

11. On behalf of LD it is submitted that:

    a. 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 LD was by discipline staff, who did not have access to his Inmate Medical Record (Dr Ranaweera, day 6, p.40). That situation is fraught with problems, and was a contributing factor to the failure properly to act upon all relevant information in relation to LD, 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.

    b. 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 (day 7, p.123). This was a real, and problematic, aspect of the difficulties caused by LD by the lack of proper care provided on 27 December 2001.

    c. Carole Draper, who had access to the IMR, commented that LD was not seen by a doctor from 18 – 27 December 2001. That belies the suggestion by Dr Ranaweera

and Dr Yisa that LD must have seen a psychiatrist. It also shows the problems in the system of providing healthcare to someone who, on 18 December 2001, was assessed by Dr Halsey at being at the high end of risk.

d. There is a complete lack of proper information before the Inquiry as to the system in place for nursing supervision in the healthcare centre at HMP Pentonville in 2001. There is only scant evidence of interaction between LD and psychiatric nurses, and there is no basis upon which this Inquiry could conclude that nursing care was appropriately supervised, or provided, to LD. There is no evidence of LD having a named nurse, or of any nursing supervisor fulfilling the function described by Professor Rogers (day 7, p.65) of ensuring that all involved are aware of the risk factors and how to manage them. This is particularly problematic given the heavy reliance upon discipline officers in healthcare. For example, the clinical decisions in relation to LD on 27 December 2001 were all made by discipline officers with no healthcare involvement, and without reference to any nursing care plan.

e. The evidence as to handovers is that only the immediate past was considered, and even that was cursory (day 5, pages 33/34). This did not enable continuity of care having regard to an overall risk assessment.

f. The evidence as to the system of ward rounds is also somewhat vague. Mostly these took place without the individual prisoner being present, in Dr Yisa's office (Dr Ranaweera, day 6, pp.43-44). The fact that the lack of visiting psychiatric involvement in LD'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 LD's care or case management (despite him having been referred to the Chaplain, Samaritans and listeners on 4 December 2001 – Carole Draper para 3.10). Nor did they involve discipline staff, who appear to have been most involved in the care of LD.

Carole Draper notes that at no stage was there multi-disciplinary involvement in a case conference regarding LD (at para 6.3.1).

g. 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. It is striking that a great deal of additional significant information regarding LD was elicited from Dr Yisa and Dr Halsey than from staff on the healthcare wing attending to LD. That is indicative of the importance of a proper approach to history taking in relation to mental illness. Moreover, it belies Dr Cummings' suggestion that LD had not made repeated reports of hearing voices. The reality is that LD reported hearing voices to the two trained health professionals who took any semblence of a detailed history from him. He is likely to have reported them to others if he had been given similar professional attention from others. That is likely to have contributed to their failings as regards the care of LD both leading up to, and on, 27 December 2001. This is considered in more detail below.

h. The system for referrals for psychiatric assessment and/or treatment was fundamentally flawed and/or failed woefully in the case of LD. This is established by the fact that LD 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 LD on 18 December 2001 and was sufficiently concerned to list LD 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 LD was under the old or the new system), this inquiry can only conclude that those systems were flawed in operation in the case of LD.

i. Dr Ranaweera, LD's allocated doctor, clearly failed to comply with her obligation to ensure that LD's proposed plan of treatment, i.e. assessment by a visiting psychiatrist, actually took place. Moreover, there is no evidence that the system she described in her evidence of requesting information from other agencies took place (day 6, pp.16-19). This is critical in the case of LD. LD 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, which she should have obtained, or inquired at the time of her first assessment of LD, would have disclosed the incident of 14 June 2001, which incident records the most detailed psychiatric evaluation of LD to be found at any point. The interview notes run to 9 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 trialed, and LD's reports of voices telling him to harm himself would have been taken more seriously.

j. The evidence also suggests that the system whereby an allocated doctor is responsible for one prisoner in healthcare, and deals with all day to day issues as regards that prisoner (day 6, p.20), did not operate in the case of LD. Dr Ranaweera described this as making sure that the prisoner was getting the care which they were supposed to be getting (day 6, p.22). There was a clear failure in this regard in relation to LD.

k. 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 LD. No attempt appears to have been made to identify risk factors, minimise these, or to manage LD in order to anticipate or adequately prevent incidents of self harm. Rather, the approach was reactive, dealing with LD after outbursts of aggression or self harm.

l. There were numerous indicators that LD was at risk, and should have been regarded as at the higher end of the scale of risk of serious self harm. He should have been seen by a visiting psychiatrist, and there is a real prospect that that may have made a difference in terms of effective anti-psychotic medication, a prn medication prescription which could have been utilised with effect in the morning of 27 December 2001, a proper dose of anti-depressants, instructions for care planning which would have included appreciation of risk factors and means of managing LD, an appreciation of the trigger factor of bad news in relation to his daughter, an appreciation of the importance of not leaving him alone unsupervised upon receipt of bad news in relation to his daughter, an awareness of the severity of LD's problems on the part of those caring for him, and possibly, transfer to a mental health hospital. These are considered in more detail below.

m. There were serious failings on the day of 27 December 2001. Indicators of risk were not heeded, and there were clear issues as to communication. This is considered in more detail below. It is in regard to the failings on 27 December 2001 that the responsibility of the State is most clearly demonstrated.

n. Against the backdrop of what was known of LD, the act of leaving LD 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.

o. There were a number of options available: LD could have been kept with someone whom he knew and trusted, care planning could have anticipated how LD should be managed in the event of bad news, Nurse Chikuku or another officer or nurse on the landing could have been asked to remain with LD until further arrangements could have been made (there were clearly a number of nursing staff available on the landing – Officers Hayward, Murray, Leane, Richards, PSN Ansong, Agency Nurse Chikuku, Agency Nurse Owuhu, and PSN Rodrigues were all on the R1 Landing at the time), Officer Leane could have

remained with LD, LD could have been taken to Ward Three as an interim measure just to avoid immediate isolation, a listener could have been contacted and LD could have remained in the Office until the Listener arrived, LD could have been put into a shared cell for an interim period, LD could have been kept in the office until a social worker or someone from probation arrived. None of those options was even considered. Instead, LD was left in the situation of maximum risk. It cannot be doubted that, if not left alone, LD would not have been able to hang himself when he did.

p. All of this must be considered in the context of LD who was known to be compliant with medication (at times demanding it), who appears to have reacted positively to such medication as was administered on 4 December 2001 (Professor Rogers, day 7, p.24 - the lack of medical records make it difficult to put it higher than this, and there is clear uncertainty as to what medication LD was in fact on as at 27 December 2001, there being some possibility that antipsychotic medication and/or antidepressants had been prescribed whilst LD was at HMP Pentonville, but clearly without any visiting forensic psychiatric involvement or detailed management plan), and it having been observed that LD actually enjoyed 1:1 supervision (Officer Leane clearly stated to Carole Draper that LD was all right with 1:1 supervision and Officer Richards told Carole Draper that LD enjoyed the 1:1s). Even if psychiatric medication had been prescribed to LD whilst at HMP Pentonville there was clearly no PRN medication administered on 27 December 2001, and there is a real prospect that a full and detailed psychiatric evaluation by the recommended visiting psychiatrist would have lead to a combination of medication and treatment plan which would have had a real prospect of averting the outcome for LD on 27 December 2001.

q. The submission on behalf of LD is that there were many steps short of a formal 1:1 watch which could, and should have been taken. However, it is noteworthy that there was also clearly a lack of understanding as to the process by which someone could have been placed on a 1:1 watch. Officer Leane said to Carole Draper that LD would have to have been seen by a doctor to be put on a 1:1

watch. Officer Hayward's evidence to the inquiry (day 4, p.34) was that the senior officer could authorise a 1:1 watch, but then said (at p.37) that in practical terms you then had to find someone to do the 1:1 watch.

r. There were also clearly some delays in cutting LD down after he was discovered by Nurse Chikuku. The Inquiry did not accede to a request for expert evidence to ascertain whether or not these delays could have been causative. However, there is a real prospect that it could have been. This is considered in more detail below.

12. Given that the systemic issues beyond those identified above were identified in the Opening Submissions on behalf of LD, and are also referred to in the various reports before the Inquiry, eg HMCIP report 1999 – healthcare is a disgrace (p.3), Suicide is Everybody's Concern – May 1999 (recommendations not followed in HMP Pentonville), the Board of Visitors Annual Report 2001, and are clearly ongoing, it is not proposed to further rehearse such issues in these closing submissions.

Detailed Submissions supplementing the Submissions set out Above

Lack of Psychiatric Training

13. The difficulties caused by the lack of detailed psychiatric training is clearly evident from Officer Hayward's response to LD's distress after the telephone call on 27 December 2001, commenting that *"we have a lot of people threaten self harm. If I put an Agency Nurse on constant observations on every inmate because he's a bit vulnerable then we would have a whole landing of Agency Nurses. Knowing Dunn from what I did, he was always a little bit demanding as such ...*" (Carole Draper interview). This shows both the lack of psychiatric training, lack of skilled observation skills (as described by Professor Rogers, day 7, p.67), 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.

14. The evidence is that observation requires an exercise of professional expertise, engaging even if a prisoner is not at first willing to do so (eg Dr Ranaweera, day 6,

p.32). Discipline officers were clearly not trained to do this. Further, 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 (day 7, p.67). Her job was, of course, made all the more difficult by her lack of previous contact or relationship with LD, and having to observe from outside a locked door. Nurse Chikuku's lack of experience, (day 5, pages 14-16) having started her first psychiatric job at St Ann's Hospital in the summer of 2001, 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.

Care Planning

15. Whilst there was evidence before the Inquiry as to a system of care planning, there is no evidence of any proper care plan for LD, or of this being implemented and modified to take account of the developing information. Professor Rogers was quite clear as to the content and purpose of a proper care plan (day 7, pp.62-64). This should have been in place in HMP Pentonville in 2001 (Professor Rogers, day 7, p.64). A nurse should be able to pick it up and immediately learn what he or she needs to know to manage the patient and his risk factors. If such a care plan had been in place it is highly unlikely that the events of 27 December 2001 would have unfolded as they did, or that the fact that LD had not been seen by a visiting psychiatrist could have gone unnoticed (Professor Rogers' evidence was that this was part of the role of a psychiatric nurse, and he gave detailed and cogent evidence as to what would be expected from a care plan).

16. The use of proper care plans was particularly important given the heavy reliance upon agency nurses (day 7, p.70).

Indicators that LD was at risk

17. The detailed chronology served together with these Closing Submissions shows numerous indicators of risk. Of particular significance are:

a. LD had many of the indicators of risk: his age, history of self harm, alcohol and substance abuse, borderline personality disorder, relationship problems, history of contact with psychiatric services, suicidal intention, and serious suicide attempts.

b. The information from the letter dated 19 August 2000 from Tower Hamlets NHS Trust indicating that LD had a personality disorder of the emotionally unstable type with poor impulse control and had previous treatment with anti-depressants whilst in YOI Feltham.

c. Officer Leane's description to Carole Draper of LD as a very poor coper, especially to do with his family, with his girlfriend.

d. The serious self harm incident on 3 December 2001 which occurred after LD, whilst in a single cell, blocked his observation panel.

e. The statement of 3 December 2001 that LD would kill himself.

f. The note on 4 December 2001 that LD was becoming paranoid and hearing voices, and the later observation that he appeared mentally unstable. Also, a statement on 4 December that he did not want to live (Carole Draper at para 3.11).

g. Dr Yisa's account to Carole Draper was graphic: LD having told him *"Doctor these voices in my had please help me stop them, please give me something to stop it"*, and asking for medication. He described LD was just really acutely distraught. Dr Yisa also told Carole Draper that although LD complained of voices in his head (from which it could be inferred that this happened more than once) he was upset about his family. He also said that he was desperate not to lose his family. He also said that LD was *"capable of impulsive behaviour particularly if he just received bad news"*.

h. On 6 December he said he was very anxious about his daughter and was seen to rip up and attempt to conceal a bed sheet (Carole Draper at para 3.12).

i. On 7 December he said that they would not stop him self-harming if he could not see his daughter, having just self-harmed (Carole Draper at para 3.13).

j. The attempted hanging with a sheet whilst in his cell on his own on 13 December 2001, which occurred in circumstances where LD was seeking attention and medication (indicating clear distress) and was required to remain on his own in his cell. This showed the failure in risk assessment by the staff, as that very morning they had assessed him as not suicidal or depressed (Carole Draper at para 3.17, commented on by Professor Rogers, day 7, p.27). This is of particular significance given the general association between the violence of a suicide attempt and the likelihood of it being repeated (day 7, p.15 Professor Rogers, accepted as logical by Dr Cummings day 7, p.133), and of it as showing that with LD there may be, in Professor Rogers' words, a period of calm before a storm (day 7, p.26).

k. On 16 December he had a period of head banging and linked that with missing his daughter (Carole Draper at para 3.19).

l. The observations of Dr Halsey on 18 December 2001 that LD repeatedly returned to the theme of wanting to die and his attentions to kill himself, his reports of auditory hallucinations in which he heard the voice of his ex-girlfriend telling him tot kill himself which he had acted on in the past, and Dr Halsey's impression that he was towards the higher end of risk (day 7, p.116) necessitating him taking the unusual step of listing him for urgent psychiatric assessment himself (concern above and beyond the majority of people I see – day 7, p.111). Earlier that day, again illustrating the poor assessment skills of those caring for LD, and the failures apparent in his care, a case conference determined that he was not mentally ill nor actively suicidal (Carole Draper at para 3.20). As is clear from the evidence of Professor Rogers, self harming behaviour in someone who also complains of command hallucinations is of particular significance (day 7, p.16).

m. On Christmas Day at 1645 LD was noted to have said that he was going to die that night, and that he was not alright, but would not elaborate. There is, of course, a real prospect that a trained professional may have been able to elicit more information.

n. Professor Rogers' view is that LD was showing signs of psychosis, and that that is consistent with the diagnosis of borderline personality disorder where psychosis may well be transient (day 7, p.37).

o. Dr Cummings described LD from his history prior to 27 December as impulsive and chaotic (day 7, p.144). Dr Cummings also said (day 7, p.145) that it was a given that with someone like LD bad news might lead to a self-harming event, and that the 13th December was relevant in terms of him not being left alone (day 7, pp.145-6). He also hoped that those assessing risk on 27th December would have been aware of the events of the 13th (day 7, p.146) although unfortunately they were not. Dr Cummings also described the risk from bad news as one of the things the prison can try to minimise (day 7, p.149).

p. There is no support for the view that LD was fabricating his symptoms. Clearly Dr Yisa and Dr Halsey took his reports seriously, and did not doubt that the reported symptoms were genuine.

18. In the light of these factors, it was clearly the case that:

a. Prior to a forensic psychiatrist reaching a diagnosis LD had to be treated as if he may have had a psychiatric illness, and he clearly showed signs of psychosis. Prior to a definitive view being reached, those caring for him had to err on the side of caution (Professor Rogers, day 7, p.21). Unfortunately, this is not what Officers Hayward and Leane did.

b. His acute distress may well have been ameliorated by appropriate medication. Professor Rogers (day 7, p.56) 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.

c. His condition on the morning of 27 December 2001 may well have responded to PRN medication.

d. LD's demands for medication and statements to Dr Yisa are consistent with medication easing his distress.

e. The assessment of Dr Halsey, the only properly trained professional to have assessed LD, is highly instructive. Dr Halsey clearly thought that urgent forensic psychiatric assessment was needed in order to assist in managing LD (day 7, p.113), and elicited telling information as to risk. Dr Halsey clearly regarded him as at high risk, relative to others, and clearly believed that psychiatric management would assist(day 7, p.116).

f. It would be wrong to make any assumption as to LD not having command hallucinations other than when he spoke of them to Dr Yisa and Dr Halsey. The reality is that LD may well not have spoken to others of them (Professor Rogers, day 7, p.39), and it is not known what was recorded in the IMR, or if he was ever properly questioned about his symptoms on other occasions. In oral evidence, the only point Dr Cummings made as to these were that they were contextual (day 7, p.110) but in evidence he accepted that his view was undermined by the fact that he never saw LD. In this regard, Dr Halsey's response to LD's presentation must obviously be the primary guide, i.e. that he urgently required psychiatric assessment and was at the higher end of risk.

g. LD was, and should have been appreciated to be, at high risk of self harm and in need of psychiatric management, including detailed care plans and an appropriate regime of medication.

<u>The Need for Psychiatric Involvement</u>

19. Dr Ranaweera was quite clear in her evidence that LD required assessment by a forensic psychiatrist for a variety of reasons. It is plain that he was never assessed by a forensic psychiatrist. One possible reason for such assessment would be to consider the prospect of transfer to a psychiatric hospital (Dr Ranaweera, day 6, pp.70-73l and bundle 8 tab 6). LD was twice put on Dr Akinkunmi's list, on 5 and 19 December 2001, but was not seen. Dr Halsey himself put LD on Dr Akinkunmi's list and stated

that he should be seen at the earliest opportunity. All qualified professionals concurred that he required expert forensic psychiatric assessment, and Dr Halsey was clear (day 7, pp.127-129) that LD had a complex presentation, uncertain diagnosis, and that expert psychiatric assessment was thought to be likely to provide assistance with management and with views as to medication. The frequency of referrals is clearly indicated in the attached Chronology. Whilst it is not possible with hindsight to say precisely what steps would have been taken, there is a real prospect that this would have assisted with LD's management, and would have prevented his injuries on 27 December 2001, either by means of management plans, proper identification of risk, proper instructions as to trigger points, identification that he should not be left alone in a cell when distressed, and detailed medication management, for example PRN medication when in acute distress. Dr Halsey spoke of an evolving plan over a number of weeks, which is consistent with attempts being made to assist in managing LD from the moment of first intervention (day 7, pp.130-131). Dr Halsey also clearly averted to the possibility of medication being used to treat LD (day 7, p.131-2). Dr Cummings agreed that proper psychiatric assessment was the starting point to management (day 7, p.119), yet that did not take place for LD.

20. In the circumstances, it was clear that psychiatric assessment and treatment was urgently needed, and there was a real prospect that it would have prevented LD's injuries.

The Day of 27 December 2001

21. There are numerous concerning events on 27 December 2001:

    a. A broken razor and a noose were found in his cell during routine fabric checks. There was a clear lack of awareness of this incident on the part of those making decisions in relation to LD 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 (Professor Rogers, day 7, p.72 and was accepted as relevant by Dr Cummings day 7, pp.150-151).

b. Nurse Chikuku's evidence to Carole Draper was that LD was low in mood earlier in the day, and that he kept putting the newspaper blocking the flap so he could not be observed (this was also an indicator of risk: day 7, p.74 Professor Rogers).

c. LD became abusive and aggressive in the afternoon, smashing his locker and claiming he could not stand being banged up any longer. This is a clear indicator of severe distress, such as would, if PRN medication had been prescribed, justify its administration (Professor Rogers, day 7, p.86 would definitely have offered him medication then). Officer Hayward was of the view that this was indicative that there was a serious issue there, and believed that he was clearly frustrated about something (day 4, pp.82-83).

d. The well intentioned, but ultimately misguided, decision to allow LD a telephone call to try to calm him down, without any clear management plan in place in the event of bad news (Professor Rogers' evidence). There is also some evidence that bad news may have been anticipated – Officer Hayward's recollection in his interview with Carole Draper was that Officer Leane had told him before the phonecall that LD was having problems with his children.

e. After the phonecall LD was clearly distressed and described to Officer Leane having lost his daughter (interview with Carole Draper). Officer Leane described him as *"pretty much in a bad way"* and *"tearful and all the rest of it"* and said to Carole Draper that he was concerned about him.

f. To Officer Hayward, whom made the decision how to manage LD following his phonecall, LD 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 (day 4, pp.65-6). He would not routinely have read the IMR (day 4, p.68), and he probably would not have looked back beyond a couple of days of LD's history (day 4, p.69). He could not recollect if he was aware of LD's earlier hanging attempt on the 13 December (day 4, p.74). Thus, the clinical decision maker had no proper training in management of those at risk of self harm, and did not available to him information relevant to the assessment of LD's risk. This shows

the need for a proper and detailed care plan and proper systems of communication of clinical information.

g. There was clearly some thought of containing LD, rather than giving him proper clinical assessment (bundle 2, p.162, Officer Hayward's interview).

h. LD also told his neighbour that he was going to do something stupid because of the phone call and that he felt there wasn't much he could do to save the baby (Nurse Chikuku's interview with Carole Draper). Had there been proper meaningful engagement with someone LD knew and trusted, there is a real prospect that he would have shared this information with them, and that steps could have been made to discuss and deal with this problem with him rather than leave him isolated and unable to cope.

i. The meaningless and ultimately ineffective entry by Officer Hayward that Staff needed to be vigilant as regards LD, and the note in the F2052SH, the effect of which was never communicated to the one person, Nurse Chikuku, who was in fact watching LD at all.

j. Nurse Chikuku's evidence as to LD's state is inconsistent. She said that he did not want to speak to her upon returning from the phone call. However, her oral evidence indicated a lack of understanding of the tools of meaningful engagement, and cast some doubt upon her ability to provide helpful assessment of LD's mental state in the circumstances. She was clearly only minimally experienced in psychiatric observation, having only recently qualified. She was also clearly working at two jobs at once, and may have suffered some effects from that, (day 5, page 8).

22. 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. Offier Richards also said to Carole Draper that his recollection was that the phonecall was about ½ hour before the incident.

23. In any event, clearly LD should not have been left on his own, isolated, in a locked cell. A range of options were put forward by Professor Rogers (day 7, pp.73-74) and were in any event clearly available to avoid LD being at the situation of greatest possible vulnerability and risk. It was plainly a gross lack of care to have left him alone and isolated in the circumstances. Even Dr Cummings acknowledged that the aim would be to manage the immediate risk, and that somebody needed to talk to LD, bearing in mind what had happened to LD on 13 December when left alone (day 7, pp.158-163). He acknowledged that the last thing you would want to do would be to lock LD away on his own.

24. Further, Professor Rogers and Dr Cumming agreed that:

    a. The background indicators of risk should have been known to those managing LD on 27 December. However, according to the evidence of Officer Hayward, they were not; and

    b. Nurse Chikuku should have been aware of the events of the day of 27 December. She was not.

25. These are both serious failings which have a real prospect of having caused LD's injuries.

<u>Cutting LD down</u>

26. The account of Officer Hayward to Carole Draper was that he shouted for a pair of scissors to cut LD down but that there seemed to be trouble getting them to him. He then shouted for the emergency bag and *"This is where the support sort of went a bit awry"*. The bag then had to be found, then he had to get down to open the bag to get the scissors out. There was, in short, a number of factors which lead to delay in

cutting LD down. Officer Hayward's evidence is that the first 90 seconds is often quite critical, let alone 15 minutes. This supports the inference that a delay of even 3-5 minutes, as is likely to have been the time to shout once for the scissors, them not to come, then shout for the bag, then wait for someone to open it, then have to get down to open it, had a real prospect of making a difference to the brain injury caused to LD.

27. Officer Leane's account to Carole Draper is also consistent with a period of delay, he said that he tried to break the top noose, could not do so, and had to call to someone to get scissors or else LD was going to die. He later said to Carole Draper that *"That was the main problem, we couldn't' get him down. I couldn't get him down, not one of us could get him down"*.

28. Carole Draper also concluded that there was delay in accessing the anti-ligature scissors (at para 7.4.1).

<u>Conclusion</u>

29. In all the circumstances identified above, this Inquiry should find that there is a real prospect that LD's injuries could have been prevented if appropriate care had been taken, and that the State has not provided a convincing explanation which excludes its responsibility to protect LD in custody.

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