

## PSYCHIATRIC REVIEW INTO THE CARE OF 'D'

1. I prepare this report at the request of The Treasury Solicitors who act for The Prison Service; it has been requested as a response to the report prepared by Professor Rogers. I am a medical practitioner, employed by Oxleas NHS Foundation Trust and work as Consultant Psychiatrist at The Bracton Centre and HMP Belmarsh; I am approved under Section 12(2) of The Mental Health Act 1983. A Curriculum Vitae is attached at Appendix 1
2. I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion. I am aware of my overriding duty to help this inquiry on any matters within my expertise and this duty overrides any obligation to the person/s from whom I have received instructions.
3. To prepare this report I have used a large body of information which is listed in Appendix 1.

### **Caveats**

- I have not interviewed D
- As has been recorded on many occasions, potentially crucial information is missing – particularly the IMR and F2052SH covering D's time in HMP Pentonville.

### **Summary**

4. This review is to assess the mental health care of D during his time in custody at HMP Pentonville during the period 30.11.2001 to 27.12.2001.

### **Summary of available information on D – prior to arrest**

5. D was born on Christmas Day, 1979 (and thus 22 at the time of the hanging in 2001). In an interview with a psychiatrist in 2001, I note that he was born with jaundice and by caesarean section. He was from Clacton on Sea in Essex and is reported to have had a difficult childhood. His father left when he was very young and in one of the reports, it is reported that his mother was an 'alcoholic'. His mother died in 2000, (though from a report in 2001, he stated it was in 1997). He is reported in 2002 to have no contact with either his sister (who is a few years younger) or his father. I note that in a report in 2003 D had informed the interviewer that his father was dead and he had no siblings.
6. He appears to have attended a mainstream school but needed additional teaching input. In a letter from 2000 is a report of D having a conduct disorder including stealing and playing truant at both primary and secondary school. He had problems

with literacy and left school without any qualifications to become a labourer. In the interview in custody at HMP Pentonville he had told the interviewer that he had left school at the age of 10 and was largely unemployed afterwards. In 2001 he had told a psychiatrist that he was a problem child who broke into cars and stole. Self harm was present from an early age and in an interview in 2001 he is reported to have required an operation to his right wrist after he punched a window out and in 1997 had a skin graft after putting his hand through a window. He had undertaken a course in 'stand fitting' and had worked as a labourer and scaffolder. I am unsure if D has a current partner but at the time of a report in 2002 he is known to have had a partner. He has a daughter who would now be aged 6 – I note that in 2004 the mother of their child did not want him to have contact.

7. D also has a considerable history of offending and since 1994 it is reported that he has been charged with 32 offences and received 11 convictions; he has had around 10 custodial sentences. He told a psychiatrist in 2001 that he had been in prison on around 11 occasions and this included ABH, GBH, Taking and driving away, criminal damage, possession of an offensive weapon and with intent to use. He also had convictions for burglary, assaulting a police officer.
8. In 2000 D was in prison at HMYOI Feltham. He told a psychiatrist at The Royal London Hospital in 2001 that he had been on Prozac in prison for around 5 weeks but the medication did not work. He had been in a safe cell for hitting other people. The documents inform us that prison 'in-reach' services wrote to the locality learning disability services in Tower Hamlets. At that time he was in the health care centre – during the course of his time there he received a 2 year probation order in which it was recommended that he sought help with his drug and alcohol use and attended an offending behaviour programme. The letter of reply from that service refers to a medical report for a court hearing on 31.7.2000; it was also commented that 'he has a diagnosis of personality disorder of the emotionally unstable type, associated with poor impulse control.' The letter refers to the use of anti-depressants whilst he was in HMYOI Feltham and that he 'has a tendency to self harm.' During his time in HMYOI Feltham a quick IQ test was administered and this gave a rough score of 65 to 70; the result of this test and the consideration of other variables meant that the Learning disability team did not consider that he was appropriate for their service.
9. There is little available documentation around events in the community. In June 2001, he was referred to a psychiatrist by the A&E Senior House Officer. The psychiatrist conducted a full history and noted that D said he was depressed but objectively he was felt to be agitated and irritable. The psychiatrist felt that he was a '21 year old man with alcohol dependency and that he had some depressive features but noted that this might be due to alcohol dependency and that he had many issues around problems with his girlfriend and the loss of his mother. Although it was noted that he felt people in the street looked at him because he was ugly and he talked to himself about his problems, no psychotic features were noted and a diagnosis of mental illness was not made. Antidepressants were not started in view of alcohol dependence.

10. In the documents there are frequent references to self harm. In 2001 he told a psychiatrist that he had taken overdoses, stabbed himself, eat glass, tried to hang himself and jumped in front of a car; D reported that this was around 2 ½ years before the assessment.
11. Although the information is limited, there are references to a 'significant' history of using alcohol and illegal drugs (reported to be cannabis, cocaine and crack). In the discharge summary from 23.7.2002 it refers to D having 'attended St Clement's Drug Dependence Unit.' He told a psychiatrist in 2001 that he had taken crack and sniffed cocaine and had been smoking cannabis since the age of 13-14. He said also that he had been drinking since the age of 8 and by the age of 13 he was drinking bottles of cider. At the time of that assessment he was drinking 'anything he can get his hands upon' and around ½ bottle of scotch and 6 to 8 beers a day. He said that he began drinking first thing in the morning. He appeared at that time to experience withdrawal and also that it led to feeling depressed.
12. The circumstances of D's remand into custody are that he was charged with theft and (it is reported in a discharge summary from June 2003) he had been brandishing a knife in the street – at first he was thought to be a danger to others but 'it was later decided that he was threatening only to harm himself.'

#### **Information on D since the events in HMP Pentonville**

13. After the incident at HMP Pentonville, D was taken to ITU at The Royal Free Hospital. D was found to have sustained a brain injury secondary to anoxia and cardiac arrest. He was ventilated for 8 days and had a tracheotomy. After two weeks he was taken to Cawshay Ward, a general medical ward at The Royal Free Hospital; an MRI scan showed bilateral symmetrical low density of the putamena (a nucleus in his brain).
14. Whilst on the ward, behavioural difficulties became apparent and additionally paranoid ideas about staff and intermittent suicidal ideation. He was later referred for an assessment by the Brain Injury Unit at Edgware Community Hospital where a number of presenting complaints were noted (poor mobility, dysarthria, dysphagia, occasional urinary incontinence, cognitive impairment and frontal lobe dysfunction, behavioural outbursts, labile mood with intermittent suicidal ideation, occasional wandering and being MRSA positive).
15. It was reported that during his time in hospital (speech and language report dated 22.5.2002) he 'has been seen by the psychiatry team who have diagnosed him with antisocial personality disorder with severe self harm behaviour.' In their discharge summary dated 23.7.2002 they report that whilst on the medical ward he exhibited occasional behavioural disturbance which included banging his head, rattling a Zimmer frame or shouting to other patients and nursing staff. He was noted to be labile in mood, sometimes being cheerful followed by sudden outbursts of tears and frustration. It was noted that he had intermittent suicidal ideation with occasional suicidal intent but no planning.

16. In June 2002 D was transferred to the psychiatric unit and remained there until January 2003. I note that in the initial part 1 summary he was noted to improve and became more settled showing rare behavioural disturbance and was noted to interact well with other patients and nursing staff. In the later discharge summary it was commented that his admission to Nicol ward was characterised by disturbed behaviour and aggressive outbursts. As D improved he failed to grasp that he needed further rehabilitation, this led to frustration and disturbed and agitated behaviour. This manifested in setting off fire alarms, smashing windows, lashing out at staff and deliberate self harm.
17. In August 2002 his care was transferred to another consultant. In early September he went to Edgware Hospital to be assessed by the Brain Injury Unit (it was commented that it had taken so long for a bed to become available at Putney Hospital). After his assessment he refused to get into the car and later he was placed under Section 3 Of The Mental Health Act 1983. Back at the hospital his behaviour continued to deteriorate and he required 1:1 or 2:1 nursing. Being on Section 3 also precluded him from admission to The Putney Unit.
18. Later in 2002 D was referred for inpatient rehabilitation at St Andrew's Group of Hospitals and was later accepted and transferred there in January 2003. I note a medical report for the mental health tribunal dated 20.1.2003. In the report, it comments that D does not have capacity to form judgements. D has severe speech impairment and clinical signs of significant executive function. He is diagnosed as having an organic personality disorder with a presumptive diagnosis of borderline personality premorbidly.
19. At the time of the report, D was on 1:1 observations 24 hours a day; he was volatile and uncooperative. He is noted to be physically and verbally aggressive and sexually inappropriate including touching female staff and exhibitionism. They comment that he had impairment of memory, severe disturbance of speech and had made many attempts at self harm including cutting and biting himself.
20. They comment, 'At his previous placement there is a range of behaviours which appear to grow out of the combined influences of his brain damage and his pre-morbid personality.'
21. They comment on current (2003) issues around self harm, 'D has a history of self harming behaviour and has attempted suicide in the past. Behaviours have included attempting to cut himself, suffocate himself and tying ligatures. D has not shown any reduction in these behaviours. The attempted suicide by hanging and other past behaviours are consistent with this high level of risk.' At the end is the comment, 'his overall prognosis must be regarded as quite guarded considering the nature of his difficulties both before and consequent to his brain injury.'
22. In a discharge planning meeting from July 2004 is commented, 'currently D is continuing to take any opportunity to self harm, he can also be very aggressive towards co-patients and is also exhibiting sexual behaviours.'

## **Events in HMP Pentonville**

23. In addition to the details below, I have provided a graphical account of D's time in HMP Pentonville, both in terms of the events and also self harm incidents; these are provided as an appendix. The complexity of events and the relationship to other factors such as level of watch, movement etc, meant that this had the potential to provide greater clarity and understanding.

### **29.11.2001**

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D is held in police custody – PER form opened before going to court.

### **30.11.2001**

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- 0745 hours F2052SH form opened at Thames Magistrates Court after receipt of PER which notes that he is at risk of suicide/self harm and has existing injuries. Staff keep D under a special watch and check him every 15 minutes
- 1245 hours – after an appearance at court, D was found to have further unspecified injuries – ambulance called and taken to Whitechapel Hospital for treatment.
- 1500 hours discharged from hospital and taken to HMP Pentonville under constant watch.
- 1645 hours arrives at HMP Pentonville.
- D assessed in reception – arrived on an open F2052SH. Found to have deliberately self harmed on both arms and said he was depressed due to the break up of his relationship with his girlfriend who was pregnant by his friend. D said he felt hopeless about the future.
- Admitted to the health care centre (Ward 3) and given a alcohol detoxification and referred for an urgent assessment by medical staff.
- 1730 hours examined by a doctor who refers him to the visiting psychiatrist
- D subsequently has a quiet night and appears to sleep – hourly entries in his F2052SH

### **1.12.2001**

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- 1430 hours - D shows threatening behaviour and was disruptive in the ward. D attempted to throw a chair through the window of the ward office and was threatening and abusive to Prison Service Nurse (PSN) Japaul and PSN New. D continued to display threatening and abusive language stating that PSN Japaul should watch herself and pointing his fingers at her repeatedly. Staff removed D to AS3. PSN New spoke to D. He seemed miserable and moaning about his move to AS3. She gave him positive support and counselling and referred him to

- the duty doctor. It was noted that D was on 15 minute documented observations and that D needed to have his mental state assessed ASAP.
- 1810 hours D threatened to self-harm with a pencil. Although tearful he remained quiet for the remainder of the night and appeared to sleep for most of the following day.

### **03.12.2001**

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- 0940 hours D self harmed by stabbing himself in the arm with a knife to re-open a cut on his left arm. D said he would kill himself by next Friday, before he has his court appearance. He was also threatening to harm staff and his ex girlfriend. He spoke about getting a gun to shoot others or using a knife. D was referred to his doctor, Dr Ranaweera.
- A doctor took a full history. D admitted that he had a history of self harm and had previously been in a YOI but this was his first time in an adult prison. D said he had left school at 10 years old and had mostly been unemployed since then. He admitted to a heavy alcohol habit. He had lived with his girlfriend for 2 ½ years and had a child by her. He was anxious and seemed to have multiple superficial lacerations to both arms, but was not considered to be either actively suicidal or clinically depressed. He was referred to the visiting clinical psychologist for counselling and a visiting psychiatrist for a mental assessment as well as the Chaplain, Samaritans and Listeners.
- He later settled for a while and took part in association during the afternoon.
- 1940 hours D was found to have obscured the observation panel of his healthcare cell H1-09 with a t-shirt. Officer Parry attended the cell and attempted to enter but D had placed a chair between the bed and door creating a barricade. D was seen holding an item to his own throat. This item was discovered to be a piece of porcelain from his toilet and was removed. D had inflicted multiple lacerations to both arms and made a small cut to his neck.
- D was attended to by health care staff. He was then relocated to Ward 3 where he remained tearful and low in mood.
- 2115 hours: seen by a doctor at 2115 hours who prescribed some medication and referred him urgently to the visiting psychiatrist.
- Dr Ranaweera completed urgent referral to Psychiatry/Psychology, North London Forensic Service. The reasons for referral are recorded as alcohol abuse. Past history mental illness – referred to St Clements Hospital in the past, history of self harm and on F2052SH. Violent behaviour, smashed 2 cells. Relationship problems – urgent assessment by clinical psychologist for counselling.

### **04.12.2001**

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- 0830 hours D was moved from Ward 3 to H1, AS3, following an act of self harm. D was described as hysterical, agitated and uncooperative, and he claimed that he could hear voices that were telling him that they were going for his daughter.
- 0845 hours D kicked the side toilet panel unit in AS3 until it fell apart. He was put on report and moved to H1-24. He later seemed to have calmed down, however he still claimed that he would harm himself, given the opportunity.

- Ds behaviour deteriorated and he was becoming paranoid and hearing voices.
- 1100 hours: D consented to emergency sedation by Dr Yisa, the Senior Medical Officer (SMO) after being considered at risk to himself and others and was placed on a documented 15 minute watch. The SMO requested an urgent referral to psychologists and psychiatrists and instructed that D was not to be given any further medication on 04.12.01 or 05.12.01.
- Case conference held during the morning, attended by medical and nursing staff. D was placed on a one to one watch for at least the next 24 hours and referred to the Chaplain, Samaritans and Listeners. An urgent referral was made for assessment by the Clinical Psychologist and Psychiatrist. Dr Yisa was involved in this conference.
- 1200 hours D ripped off the dressings from both of his arms and told staff that he did not want to live. He then slept for the remainder of the day.

### **05.12.2001**

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- D slept during the morning. He participated in association during the afternoon but then returned to bed and slept.
- D was assessed by the doctor who kept him on a one to one watch and noted that he was awaiting assessment by the psychologist and psychiatrist.
- Appointment with Dr Akinkunmi (North London Forensic Service) was not kept.

### **06.12.2001**

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- D was due to have a legal visit but this was cancelled because he was not feeling well. Physical observations were ordered on D on an hourly basis.
- Case conference attended by Dr Yisa.
- 1815 hours D woke up and spoke to staff. He appeared low in mood and explained that he was anxious about his daughter and his situation.
- D was later found ripping up a bed sheet which he attempted to conceal in his cell. He voluntarily gave up the sheet when asked to do so.

### **07.12.2001**

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- D went to Thames Magistrates' Court and was further remanded in custody at HMP Pentonville until 14 December.
- At court D was seen to be removing dressings from his arm and was later found with blood on both arms having self harmed with pieces of broken tile from the bathroom at court. He told staff that they would not stop him self-harming if he could not see his daughter. He was seen by the Forensic Medical Examiner but was not given any further treatment. He was returned to HMP Pentonville for further assessment.
- Returned from court very tearful and complaining of 'lock-jaw'. Procyclidine given and the doctor was asked to review.

### **08.12.2001**

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- D was more settled. The day passed without incident. D participated in association and took exercise. D was seen by a doctor and was kept on one to one watch.

### **10.01.2001**

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- Case conference held. It was felt that D was far more settled, with no thoughts of self harm or suicidal ideation. F2052SH kept open and level of observations was reduced to 15 minute observations.

### **11.12.2001**

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- Case conference held. Observations reduced to 15 minute supported observations.
- D was also referred to the Education Department so that he could participate in the education programme for Health Care on the R1 landing.

### **13.12.2001**

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- Further case conference held. D was considered to have settled well and not to be either clinically depressed or suicidal.
- It was proposed that D be moved out of the Health Care Centre to normal location and that he be put into a shared cell. It was decided that his F2052SH should remain open. His referrals should be maintained and he should be assessed by the visiting psychologist and psychiatrist in the outpatients department. A support plan and discharge report were drawn up in the F2052SH.
- D was brought in from exercise wanting something to help him sleep though the day. D was informed that there were no doctors available as they were in a clinical meeting. D started throwing his furniture around his cell. R1-21 and shouting verbal abuse of a highly charged and sexual nature.
- 1400 hours D attempted to self harm by tying his bedding around his neck. PSN Abani raised the alarm. PSN Smith entered his cell and cut him down. No loss of consciousness was observed.
- D was seen by the doctor who authorised a documented 15 minute watch, referrals to Listeners, Samaritans and Probation. The doctor also authorised that D be moved to a semi-furnished cell with special clothing and bedding. Items with which he could self harm were removed from the cell. D appeared to settle.

### **14.12.2001**

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- D attended court under constant watch by Securicor staff. He returned to HMP Pentonville and was returned to cell AS3, a semi-furnished cell and placed on a documented 15 minute watch until he was seen by the doctor.

### **15.12.2001**

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- The following day he was moved from AS3 to R1-21, a single cell. He remained settled, interacting with staff and other prisoners.

### **16.12.2001**

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- 1500 hours D had a period of head banging, telling staff that he was missing his daughter. He stopped this after he had talked with staff. D then went on association.

### **17.12.2001**

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- D appeared to settle.

### **18.12.2001**

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- D had a social visit, which did not cause him any obvious distress
- A case conference was held. It was felt that D was not mentally ill, nor clinically depressed. He was anxious about his present situation but not actively suicidal. It was decided that his F2052SH should remain open and that he should remain in Health Care for mental observation, subject to 15 minute supported observations.
- D was seen by R Halsey, the visiting Clinical Psychologist, who described him as presenting as tearful, depressed and miserable. D claimed that he could hear his girlfriend's voice telling him to kill himself. Mr Halsey said that he would see him again in the New Year but in the meantime, D required a thorough psychiatric evaluation. D was listed for the visiting psychiatrist the following day. Mr Halsey notes that if D is not seen for any reason then he should be included on the list of one of the visiting psychiatrists at the earliest opportunity.

### **19.12.2001**

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- 1200 hours D became angry and started throwing things around in his cell. He was unwilling to tell staff why. He was apprehensive during the night about his forthcoming court appearance.
- D is listed to see the psychiatrist, but is not seen.

### **20.12.2001**

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- D attends court and returns to HMP Pentonville without incident during the evening.

## **20 to 24.12.2001**

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- D participated fully in the Health Care regime, interacting well with staff and other prisoners. Entries into the F2052SH suggested that he was in quite a congenial mood

## **25.12.2001**

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- 1645 hours, Christmas Day, D had called out to another prisoner that he was going to die that night. He told staff that he was not alright but would not elaborate on this.

## **27.12.2001**

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- During the cell fabric checks during the morning, D was discovered with a broken razor in his cell and a noose. He told staff that the former was for cutting matches and that the latter was only intended to be a joke. The member of staff who made the discovery reported the finds to senior staff on duty and continued with his duties.
- There are a few entries in the F2052SH to cover the morning, but it would appear that D remained quiet for the period. He appeared to sleep during the lunch time period.
- Nurse Chikuku reports that D kept putting the newspaper in front of the observations hatch so that she could not see into the cell. She informed one of the officers.
- Officer Leane agreed that D could have a phone call.
- It would appear that D remained quiet and he slept during the lunch time period. At about 1500 hours D became abusive and aggressive. He smashed his locker stating that he could not stand being 'banged up' any longer. Staff removed the furniture from his cell as a precaution.
- It was agreed that D could still have the phone call. Officer Leane escorted D to the office and made the call.
- During the phone call, D learned that his daughter had been taken into care by social services. He was tearful and distressed after the call. Officer Leane took him back to his cell. He then went to tell Senior Health Care Officer (SHCO) Hayward what had happened.
- An entry was made in the F2052SH and Health Care Observation Book that staff should be extra vigilant in relation to D.
- D obscures observation hatch with newspaper. Agency Nurse Chikuku removes this so that she can carry out her observations. She discovers D attempted to hang himself and raises the alarm.
- D was hanging suspended from his cell light in R1-18. Officers Leane, Murray and Richards attended the scene with SHCO Hayward. They supported his weight and cut him down. SHCO Hayward inserted an airway and commenced CPR. D was given Adrenaline by Dr Khan. He was fitted with a spinal collar in case of spinal injury. The air ambulance team (HEMS) arrived. They intubated D and had him put on to a spine board.

- 1633 hours D was then transferred to the Royal Free Hospital by land ambulance and was escorted by Officers Leane and Murray.
- Initial prognosis from the medical staff at the Royal Free was discouraging. Arrangements were made for his next of kin to be contacted.
- There were indications that D was going to remain in a permanent vegetative state. Criminal charges were dropped and D was discharged from custody. However, when contacted in 2002, the Royal Free reported that D was conscious, up and about and was recovering well.

## Diagnosis

24. Before looking at care and risk, I believe that central to many issues, should be an attempt at establishing a diagnosis. It has links to risk, the importance of psychiatric involvement and also his management in the health care centre at HMP Pentonville. **Overall, for the reasons mentioned below I am not persuaded that in December 2001, D had a mental illness** and in my opinion, he most likely had an emotionally unstable personality disorder, borderline type i.e. a mental disorder. I will set out these reasons after briefly considering the difference between a mental disorder and mental illness.

### The difference between mental illness and mental disorder

25. I note that the term mental illness has been used on a number of occasions by various parties including Professor Rogers in his report. There is often some confusion about the terms mental illness and mental disorder. In terms of The Mental Health Act 1983, mental disorder is the umbrella term for all the underlying conditions such as mental illness, personality disorder (or psychopathic disorder), learning disability and 'any other disorder or disability of mind.' In effect this is a wide definition and can capture many conditions or issues. There is sometimes a requirement when implementing orders to specify one of the four subtypes i.e. mental illness, psychopathic disorder, mental impairment and severe mental impairment. This is the case with D's more recent detention in that he is detained under the category mental impairment, the latter being secondary to anoxia/brain damage – he is not detained under the category, mental illness.
26. Mental illness, the category for which accounts for the largest number of admissions under the mental health act, is undefined. In practice clinicians use the term to describe major clinical conditions such as schizophrenia, depressive illness (not just feeling depressed or depression as a feature of other conditions such as personality disorder), other forms of affective disorder such as bipolar disorder, schizoaffective disorder.
27. I have laboured the point for a particular reason. For remand prisoners (and therefore subject to Part 3 of The Mental Health Act 1983) there are a number of routes to clinical care outside of prison and within the NHS and/or the private sector. The routes to care are either through the courts or alternatively directly through the mental health unit at The Home Office (or now Ministry of Justice). In practice and in terms

of D during his time in HMP Pentonville, if he were to have been admitted to hospital (as suggested by Professor Rogers), this would most likely be via the court under Section 35 (remand to hospital for preparation of a report) or direct via the Home Office under Section 48 Of The Mental Health Act 1983. Other sections which might have been heard of such as section 37, 38, require a conviction. The other option, under Section 48 **would require a finding of mental illness** (or the alternative category of severe mental impairment) it would also require that two clinicians find this and that a bed in a suitable secure unit is available. As I will explain, this route would not be likely in view of my belief that D did not have a mental illness. It is important to note that transfers to hospital are particularly complex and can take many months.

### **Diagnosis in D**

28. Clinicians such as psychiatrists make a diagnosis using a combination of information and clinical observation. The information is ideally from the patient and encompasses a degree of historical information. Thus with any patient we take a history because often clues are found earlier on that have considerable bearing on the assessment process. Thus if one is depressed we ask how long and try to identify whether there was a precipitant that we can relate this to. When assessing D we would explore his early life as much as the current issues to consider whether there are issues that relate to his personality as much as mental illness. Thus a greater insight into understanding and describing personality usually requires an exploration of childhood and adolescence. Thus it is important to consider the whole as much as the specific time or certain issues that are manifest at one point.
29. Earlier I commented that I was not persuaded that D has nor had a mental illness. I have come to this conclusion based upon the following.

#### The nature of his symptoms:

30. I would suggest that the central thrust of the belief that D had a mental illness was that he said that he heard voices during his time in custody (08:30 & 08:45 on 4.12.2001 and to R Halsey on 18.12.2001) and to a lesser degree that he was paranoid and had periods of being depressed. This might suggest initially that he has a mental illness such as schizophrenia. Modern psychiatry has given us better insight into illnesses such as schizophrenia and we have a number of classification systems (e.g. ICD10 and DSM4) and research tools to assist us. It is also important to note that great caution should be exercised in making a diagnosis as it has important implications e.g. in terms of treatment and is often stigmatising.
31. I would not agree with Professor Rogers's comment, 'I would have expected, given D's clinical presentation at the time, that had a psychiatrist assessed him, that any reasonable body of psychiatrists would probably have concluded that D was suffering from psychotic symptoms.' (P39 of his report). In my opinion most psychiatrists (and particularly those who work or visit prisons) would not make a diagnosis of mental illness or psychosis on the basis of these observations alone. There are many more questions to ask about the nature of such symptoms before deciding that this is mental

illness, furthermore a diagnosis of mental illness is not made on the basis of one symptom especially when his overall presentation and symptoms suggests other diagnoses. To use the analogy, just because one has some bricks does not mean that one has a house – a house requires more than just bricks alone.

32. Reports of 'hearing voices' is a regular occurrence in a prison population and most psychiatrists who work in such an environment would exert caution about both the presence of such symptoms and what they represent. There is limited useful research on this issue though there is more literature on prisoners who feign mental illness; for instance in a study of referrals to a medium secure unit in County Antrim found that 32% of the sample ( $P < 0.01$ ) could be classified as fabricating or exaggerating symptoms of mental illness. (Journal of Psychiatric and Mental Health Nursing Volume 4 Issue 1 Page 9-15, February 1997).
33. I would stress that I am not suggesting or concluding that D feigned mental illness and taking into account the unfortunate condition that D now finds himself in makes the issue a clearly sensitive and delicate area to broach. It is important to note though that such claims have the potential for gain, such as access to treatment/medication, being located in a different area of the prison and also as a route out of custody.
34. Most clinicians who work in prison, will meet reasonably regularly, prisoners who claim such symptoms but find that the symptoms are neither consistent or their description does not equate with typical psychopathology. Thus for example many prisoners when questioned about hearing voices state that they experience these inside their head, whilst a true hallucination is like a normal perception, i.e. located in external space. It is important to note that the clinical view above should not necessarily detract from the claim – thus we are not trying to make a prisoner look foolish or 'catch him out.' It is possible to conceptualise the claim as being either directly or indirectly an expression or representation of distress.
35. Transient experiences of this nature are also common in prisoners. One reason is due to the concomitant use of alcohol and/or illegal drugs and their withdrawal and another might be transient phenomena in conditions such as borderline personality disorder.
36. Additionally, the comments of hearing voices are entirely self reported. I note that D was never seen to respond to or be influenced by auditory hallucinations (at its simplistic – talking to himself) outside of these comments; although there are obviously periods of high distress, for at around half of the time in HMP Pentonville D is quite settled and no symptoms have been commented upon. One might expect that ongoing symptoms of auditory hallucinations in mental illness would be noticed in other ways apart from two instances of self report.
37. In my opinion his claims of hearing voices should be taken into context with his remand into custody and as such should be seen as a conceptualisation of the marked distress that he felt. It is interesting to note that his reporting was made on only two occasions and in the latter with Dr Halsey the content was related to one of the areas

that he was most worried about, that of his daughter. If present, they were most likely transient phenomena and not indicative of a pervasive mental illness.

#### The continuum of his condition

38. The documents suggest that before D came into custody there was no history of mental illness and secondly after the events, mental illness has not been detected – indeed since the events in 2001, D is or has been managed within the category of mental impairment. The diagnosis available before remand was one of a personality disorder – I note that a number of different types have been postulated including borderline and antisocial. There is no indication that in the time prior to imprisonment, D was suffering from a mental illness. His GP has no record of this and also there seems to be no suggestion of this during his earlier time in HMYOI Feltham when he was examined by a psychiatrist – the letter of 31.7.2000 refers once more to a personality disorder.
39. It would seem less likely therefore that mental illness was present during his time on remand in HMP Pentonville and once more that such a diagnosis is based upon two self reports.

#### The assessments in HMP Pentonville

40. It would be worth considering the need for specialist services and whether the input by the SMO and the medical officers should be judged a poor second. Taking a historical perspective, the prison medical service was the oldest medical service in the UK but by the time of 2001 was in decline and being re-evaluated. Nevertheless the presence of a Senior Medical Officer and medical officers were still common place in prisons in England and Wales at that time. They represented a prison equivalent of General Practitioners. Interestingly, in the last few years, the NHS (in the form of PCT's) is increasingly pushing a primary care led service within prisons and this is particularly so in London prisons. Following the transfer of responsibility for care and funding to the NHS and the position of PCT's (Primary Care Trust's) as commissioners for the provision of care, tendering processes have taken place at HMP Wandsworth and HMP Brixton in which the desire for a primary care led service is seen as an aspirational development. I expect that this will continue elsewhere within the prison estate; one aspect that is often overlooked is the knowledge of the prison culture and the prison environment that is frequently puzzling to those who work outside prison. It is also a knowledge of prisoners that is difficult to quantify but should not be dismissed.
41. I have laboured this point because I do not feel that the input or experience of the medical team at HMP Pentonville in 2001 should be waved away as not having validity or usefulness. This is particularly so in the context of mental health. As we have seen in the documents, Dr Yisa was praised for his ability to transfer out mentally ill prisoners and so this demonstrates a competence to identify and move such prisoners out of the prison – this in itself is difficult as local providers need to be persuaded that such prisoners are in need of transfer. Considering the large number of mentally ill prisoners who came through HMP Pentonville, indicates that there was

success in their input and that they contributed considerably to the delivery of care to prisoners with mental illness and mental disorder. In essence Dr Yisa and his team could be seen as a gateway to mental health services. Because D did not have a mental illness, the medical team at the prison (and not the psychiatrists who visited) would have been responsible for his day to day care and evaluation. Thus the viewpoint (e.g. the case conference on 18.12.2001) that D did not have a mental illness should be given more credence.

42. In my opinion, although they are not psychiatrists, their assessment was probably correct. In fact although there are referrals to psychiatry and psychology, on no occasion was it put forward that D definitely had a mental illness and at least two statements from meetings state that he did not. I also note that in the earlier referral to the North London Forensic Service made by Dr Ranaweera on 5.12.2001, she expresses some doubt about the history of mental illness. This was also the opinion of Dr Yisa in his interview with Carol Draper when he clearly stated that he did not feel that D had a schizophrenic or psychotic illness (Draper report: Bundle 4, Section 8, Page 4).

#### Alternative diagnosis

43. In my opinion, the most likely diagnosis for D in the period up to his transfer to hospital in 2001 was an emotionally unstable personality disorder – borderline type. I have reached this conclusion for a number of reasons.
44. Firstly the documents beforehand indicate that this had already been put forward as a diagnosis. After the events of 2001, the same diagnosis had also been considered. You will note that this has been repeatedly stated in assessments with for instance a comment that in the St Andrew's assessment, 'a presumptive diagnosis of borderline personality premorbidly' (i.e. before he became ill with organic impairment). Also in the assessment is the comment, 'At his previous placement there is a range of behaviours which appear to grow out of the combined influences of his brain damage and his pre-morbid personality.'
45. However, the main reason for my conclusion is that the available information about his mental state and behaviour, very much supports this diagnosis. To understand this, let us consider the concept of a borderline personality disorder.
46. Personality, as it is commonly understood, is what makes one individual different from another. Personality contains a number of constraints, which are balanced in varying degrees, but when the balance is out of kilter and causes that individual or others to suffer, it is called a personality disorder. The dividing line is usually taken as when the personality disturbance results in impaired relationships and reduced or occupational functioning. The WHO definition contains the following principles:

- Markedly disharmonious attitudes and behaviour involving usually several areas of functioning – affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others.
- The abnormal behaviour is enduring
- The abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social situations
- The above adaptations always appear in childhood or adolescence and continue into adulthood.
- The disorder leads to considerable personal distress but that may only become apparent late in its course
- The disorder is usually but not invariably associated with significant problems in occupational and social performance.

47. An emotionally unstable personality disorder, borderline type, is described again by WHO as a personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective (i.e. mood) instability. The ability to plan ahead may be minimal and outbursts of intense anger may lead to violence or behavioural explosions. It is indicated by five of the following:

- 1] Frantic efforts to avoid real or imagined abandonment
- 2] A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
- 3] Identity disturbance: markedly and persistently unstable self image or sense of self
- 4] Impulsivity in at least two areas that are potentially self damaging: e.g. spending, sex, substance abuse, reckless driving, binge eating
- 5] Recurrent suicidal behaviour, gestures or threats, or self mutilating behaviour.
- 6] Affective instability due to a marked reactivity of mood e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely lasting more than a few days.
- 7] Chronic feelings of emptiness
- 8] Inappropriate intense anger or difficulty in controlling anger – e.g. frequent displays of temper, constant anger, and recurrent physical fights.
- 9] Transient stress related paranoid ideation or sever dissociative symptoms

48. Considering D, I believe that one could make arguments for the following:

49. Item 1: this may be indicated by his response to the difficulties in his relationship with his ex-partner but also in terms of issues surrounding his daughter just before the hanging incident on 27.12.2001.

50. Item 2: difficult to evaluate and other information would be needed

51. Item 3: limited information to evaluate this – but some evidence in 2001 that he felt he was ugly and thus people stared at him.

52. Item 4: there seems to be considerable evidence of impulsivity in his time in HMP Pentonville though the definition is mainly talking about substance misuse.
53. Item 5: positive evidence for this before, during and after his time in Pentonville. There is reference to previous self harm, at the time of his arrest he was in possession of a knife which he intended to harm himself with, and of course the many incidents of self harm and threats.
54. Item 6: I believe that there is good evidence for this – thus the presentation at Pentonville suggests that his mood was quite varied and prone to quick change.
55. Item 7: limited information to evaluate this
56. Item 8: There seems to be good evidence for this during his time in Pentonville – thus throwing chairs, and other incidents.
57. Item 9: this may be the explanation for the comment about becoming paranoid on 4.12.2001.
58. In terms of the last item, some researchers (Tamopolsky & Berelowitz 1984) have thought that the key items for this were a pattern of unstable intense interpersonal relationships, impulsiveness and self destructive behaviour. These workers also included ‘stress related psychotic episodes’. This latter item has been included back into a definition by DSM (diagnostic and statistical manual, version 4) which is the standard diagnostic tool in USA. The criterion is for ‘transient stress related paranoid ideation or severe dissociative symptoms.’ The latter may better explain the observation of being paranoid and hearing voices.
59. On the 4.12.2001 it was noted that D was ‘paranoid’; the use of this term then was not defined but my experience is that the term is often used loosely. Paranoia is a Greek term which means ‘to the self’ – the lay perspective is one of persecutory thoughts. Often prisoners complain of being paranoid but when asked to define what they mean results in an explanation of being anxious around other prisoners – this is not the same as either being paranoid or having persecutory thoughts.
60. In my opinion much of the clinical presentation and behaviours can be explained in terms of a diagnosis of an emotionally unstable personality disorder, borderline type. Thus D was seen to self harm and threaten to self harm, be violent and destructive, show marked mood changes such as low mood and other expressions such as tearfulness, used alcohol and illegal drugs to cope. The impulsive components are the most striking and particularly the relationship to bad news and imprisonment. There is evidence for this diagnosis in the period before and during custody.
61. In terms of parasuicide, i.e. self harm, there is a high rate of personality disorder within those who self harm. Prison populations also have a high rate of personality disorder though this tends to be more antisocial groups. Overall studies have identified that 78% of the male remand prison population have a personality disorder of one type or another. Studies such as the ONS study (Office of National Statistics:

Psychiatric morbidity amongst prisoners in England and Wales. 1997) have found rates of borderline personality disorder of around 23% in the male remand population. Clinical experience tends to confirm, that the combination of the prison environment with individuals who have such a disorder present considerable challenges. It is possible to consider that D's arrest and remand (rather than bail for instance) might have some relationship to a concern about the risk to himself; this seems to be part of the context of his arrest when he was noted to have a knife which he was threatening to harm himself.

62. Considering the high levels of personality disorder in the prison population, one might ask whether patients with a condition such as borderline personality disorder should be in prison at all and alternatively whether they should be managed by the NHS. A significant document was published in 2003, called 'Personality Disorder, no longer a diagnosis of exclusion.' In this document is a telling opening paragraph:

*As things stand today, people with a primary diagnosis of personality disorder are frequently unable to access the care they need from secondary mental health services. A few Trusts have dedicated personality disorder services but these are the exception rather than the rule. In many services people with personality disorder are treated at the margins – through A&E, through inappropriate admissions to inpatient psychiatric wards, on the caseloads of community team staff who are likely to prioritise the needs of other clients and may lack the skills to work with them. Within forensic services a number of regional secure units actively exclude patients with a primary diagnosis of personality disorder, because they do not consider this to be their core business. Many clinicians and mental health practitioners are reluctant to work with people with personality disorder because they believe that they have neither the skills, training or resources to provide an adequate service, and because many believe there is nothing that mental health services can offer.*

63. Thus to underscore my earlier comment, the presence of such a condition would most likely not be addressed by the NHS. Although not from a clinical perspective, organisationally the prison service has developed considerable expertise in managing such prisoners. It is not to be assumed that all those who become incarcerated in prison and who have a personality disorder are worse off. In some, prison provides structure and containment and detachment from extraneous provocative agents.
64. There remains considerable divergence about the usefulness of such a diagnosis and also the benefit, if there are any, of treatments. The above document recommends that in 2003 dedicated services for those with a personality disorder need to be developed and particularly forensic populations. In 2001, and either within the NHS or in prisons much of the delivery of care for patients with a personality disorder is effectively management of behaviour and/or risk. There remains considerable uncertainty of what interventions are applicable, their usefulness and also marked consideration of cost benefits.

## **Command hallucinations**

65. I note that Professor Rogers has focused on the issue of command hallucinations. I remain doubtful that D experienced command hallucinations or pseudohallucinations of the nature that is found in mental illness. Dr Yisa seems to have explored this and at the time of the draper report comments that 'he complained of voices in his head.' (Draper report: Bundle 4, Section 8, Page 4). I doubt that this is mental illness and I would therefore find less of a link to self harm and suicide and prefer to explain these in terms of an underlying personality disorder as described.

## **Self harm and suicide in custody.**

66. Before looking at national and local issues, it is worth considering the nature of the terms and some of the themes that have taxed theorists and complicated research and methodology in these areas. Firstly the terms are actually difficult to define. Suicide research is challenged by defining whether a death in custody is actually a suicide. There are a number of deaths in custody each year which are either related to physical illness or are recorded as open. Thus when interpreting statistics we must understand that suicide is of course a legal outcome established through the coroners court.

67. Self harm is another issue which is difficult to define. There are a number of terms that are used, sometimes without thought, this includes, deliberate self harm (or sometimes notated as DSH), parasuicide, self injury etc. Taking the term deliberate self harm is problematic in that deliberate implies deliberation i.e. some thought and planning – whilst we know that many acts are done impulsively. Self harm is also a difficult category in that many acts could be considered as causing self harm e.g. smoking. It is for this reason that the term, intentional self injury may be a better term to use. Self injurious behaviour is probably different in prison to in the community, thus whilst both communicate distress, self injurious behaviour in prison sometimes has another currency. One should be cautious in interpreting self injurious behaviour in the same way at all times. Looking at D there are many events which fall within this umbrella but undoubtedly they fall across a scale. One could be reasonably confident with some that there was no likelihood of actual death and therefore we should be cautious when interpreting all in the same manner and drawing too many conclusions. Whilst trying not to devalue the distress that D felt, I would argue that only the earlier hanging had any real chance of actual death.

68. Theorists remain divided over the relationship between self harm and suicide. Thus some remain of the view that they are all part of a continuum with suicide representing the far end. Others have maintained that they are distinct entities. This was the basis of Krietman et al (1969) coining the term parasuicide, which served to distinguish suicide from self harm where he argued the latter had little or no intention to die. This presents a platform to completely undermine research and evaluation. Thus many studies into suicide (because of course the subject group is dead) have turned to repeated self harmers to find themes.

69. In terms of relationships between self harm and suicide, the following premise is held to be correct. This is, that in many of those that eventually die there is a history of self

harm. The various studies have indicated that nearly half of all prisoner suicides have a history of suicide attempts and self harming behaviour [Offenders' risk of serious harm: a literature review: Beverly Powis, Offenders and Corrections Unit, Home Office Research, Development and Statistics Directorate. April 2002]. However only a small proportion of those whom repeatedly self harm go on to commit suicide.

70. Self harm and suicide are events that continue to occur in prisons in this country and across the world; additionally it has been present throughout the historical presence of prisons again across the world. There is considerable research on both areas within prisons in England and Wales. The reader of this report should consider authors such as Dooley, Alison Liebling and Graham Towl. In addition to research there have been a number of government reviews and surveys and also a thematic review by the Inspector of Prisons. The topic is closely monitored and there are published documents which appear regularly to monitor events. Nationally there are departments and locally there are teams which are part of continually changing initiative and approach to reducing self harm and suicide. I point this out because approaching a subject such as this and proposing that events such as these can be eliminated is clearly chasing rainbows. It also serves to highlight that both self harm and suicide prevention are complex issues which have taxed and occupied the prison service.
71. It is beyond the scope of this review to critique and present the details of self harm and suicide in custody. At the time of D's hanging in 2001, there would be on average each day, 1000 prisoners identified at sufficient risk to warrant management on an open F2052SH form in England and Wales. Virtually all of these prisoners would be supported successfully through their crises and difficulties. Locally at HMP Pentonville, a large number of prisoners on a F2052SH were successfully managed during their time in custody. Towl, in his book, *Suicide in prisons* (P19. *Suicide and Prisons: 2000*) quotes that 'between January 1999 and March 1999, there were 26,000 contacts of over 10 minutes duration made between prisoners and listeners. These figures give some indication of the level of work that goes on daily, unreported and that needs to be considered when judgements are being made about success and failure.'
72. Towl also quotes that self inflicted death remains a very rare event and thus is a poor outcome measure. The level of self injury is probably a better measure but adds that there is an absence of reliable standardised measures of self injury. In 2001 there were on average 5,600 self harm incidents by men in prisons in England and Wales.

### **Evaluation of risk**

73. I have been asked to clarify the issue of risk and particularly the questions:
- a) Was there a specific risk to D's life on the facts of his case as known?
  - b) What was the nature of that risk?
  - c) Were the means being used to deal with the risks adequate and if not why not?
  - d) What could and should have been done?

74. Empirical research has repeatedly identified similar findings for those who commit suicide. Thus the greatest period of risk for those on remand is in the first month and particularly the first week and first 24 hours. Risk factors such as substance misuse, contact with mental health services, having a personality disorder, previous self harm, previous periods in prison etc.
75. Overall, in my opinion, D had many of the risk factors for self harm in custody. He was on remand (and relatively early on) he had a history of alcohol and substance misuse, there was a history of self harm, he had a personality disorder, he had a history of contact with psychiatric services. Thus D was a risk to himself in custody but also in the community. It would be best to sum up his risk in terms of persistent background risk on top of which were acute periods of risk.
76. Additionally HMP Pentonville was a prison which also had many of the risk factors associated with self harm and suicide. I will not try to explore the cultural issues as these remain a matter for debate within much theoretical research; it is known that the number of suicides is higher in local prisons and those with a high turnover or high number of new receptions.
77. It would be fair to say that D had many of the risk factors for self harm and suicide in custody. In terms of the first question – was there a specific risk to D’s life on the facts of his case as known? This tends to imply that the organisation presents a risk to D and I feel that the question might be better put, ‘did D present a risk of suicide and self harm in custody?’ I point this out because D is central and though its operation and organisation clearly impinges upon D, it is the organisation which is there to manage the risk. This is also the nature of the organisations approach to self harm and suicide in custody. Thus historically much effort had been put into preventative measures such as taking away objects that might be used. In recent years (since the 1990’s) the push has been towards understanding the individual and how the risk is manifest.
78. As has been pointed out, during his time in custody D both made actual attempts and made threats. It is difficult to put a precise number on the events because much depends upon interpretation – thus should finding D ripping up a bedsheet and concealing it be considered a potential act of self harm or should it be considered a destructive act e.g. in the same way that he threw around chairs or expressed other difficult behaviours. I have tried to present the incidents in a diagrammatical format (**please find attached**), and broken these down into actual self harm (of any sort and including head banging etc), threats and events or actions that could be interpreted as self harm or suicide risk.
79. In considering the nature of the risk, it is fundamental to note that risk is not a static phenomenon. Risk is a dynamic construct and thus constantly changing. It is too simplistic to just say that D was at risk. Therefore although there were many attempts and threats, looking at this graphically, it can be seen that the bulk of both incidents and threats are clustered around the first 8 days. Thereafter there are peaks but overall

the risk is much lower than the first 8 days. There is obviously a changing pattern to risk – thus although D would always have presented a level of risk, this would wax and wane.

80. The role of substance misuse and alcohol may be relevant here. It could be postulated that D and the nature of his personality meant that he sometimes coped poorly and used maladaptive coping strategies to cope. Self harm, alcohol and substance misuse were part of the coping strategies that he employed. It is difficult to be certain of the level of dependency to alcohol and illegal drugs, nevertheless it was of a degree that warranted a detoxification. It is possible that this 8 day period was also the time in which he was still experiencing withdrawal from either alcohol or illegal drugs.
81. Taking a more macroscopic view, how we cope is an individual characteristic. Thus some cope better than others and different provoking agents provoke different responses. Outside of prison we have a range of opportunities to cope with for instance bad news. Thus we might talk to a friend or family, have a drink, go for a walk or more importantly actively try to address the problem that troubles us – for instance if a relationship is in difficulties we might try to talk it through. In prison there is a narrowing of the range of strategies that we might employ and more importantly there is not the opportunity to directly address the problem that troubles us. This is one reason why self harm and other behaviours are more prevalent as there is not the opportunity to use our other coping techniques. For those who already have maladaptive coping strategies it is compounded further. Much of the literature on the subject and its prevention, states that self harm and suicide stem from the interaction of personal vulnerabilities that the prisoner brings into the establishment (importation factors) and features of the prison environment (deprivation factors). The two components do not operate independently. Prison is a very stressful environment, considering the large number of people who pass through the overwhelming majority adjust and cope. Individuals adjust in a variety of ways and using both good and poor methods.
82. Taking alcohol and substance misuse aside, in many respects, I am not surprised at the pattern of risk and those who work in health care centres would observe similar patterns in many of its patients. Ultimately and because in my opinion D did not have a mental illness, he was responsible for his own self harm; it was for the prison service to manage and address the risk as best as it could.
83. It is important to differentiate between awareness of risk, managing risk and addressing the underlying issues that produce that risk. This has been the central theme over recent decades in the management of self harm and is part of the shifting profile of self harm and suicide prevention. The instruction to Governors, ‘Caring for the Suicidal in Custody’ was a response to the 1990, Tumin Review and saw the implementation of the F2052SH form. In addition to providing training for staff, partnership working, improving and ensuring communication and the involvement of prisoners was the removal of the requirement that those at elevated risk no longer had to be placed in the health care centre. It is to be noted that despite the implementation of this policy, nationally the numbers of self inflicted deaths rose (but also a rise in the prison population).

84. Looking at the different aspects of risk. There is of course some overlap. Thus placing D in a ward is both an opportunity to contain or manage that risk but also it attempts to address the underlying issues by providing an opportunity to talk to other prisoners. HMP Pentonville showed an awareness of risk, this can be seen in the awareness of his history of self harm and that D continued to remain a risk and so should remain on the F2052SH. In managing or containing the risk, there were a number of options which were employed and demonstrated flexibility in approach.
85. Firstly in terms of location, the health care centre used the full range of options at its disposal and used them flexibly. In practice the options were the same as for any prison i.e. a single cell, a ward, a gated cell or an anti-ligature cell. It is unclear as to whether a gated cell was used or was available but the other three options were all used. If one looks at the graphical analysis of his cell location, it can be seen that the prison tried to place him in all three environments. Historically prisons would have put prisoners in areas where they were isolated, had no furnishings, padded rooms, anti tear clothing etc. In the years before the events of 2001, there had been a shift away from this practice and this can be seen in the management of D at Pentonville.
86. Overall his management in terms of placement was a quite logical progression. Thus D, who was identified at reception as being a risk of self harm/suicide, was placed initially in the health care centre and in a ward location. Thus they had correctly identified D as being at risk and placed him in the appropriate place and not in the main prison. A ward location allows for reasonable observation, allows interaction and support from other prisoners and crucially reduces self harm and suicide attempts – the rationale being that a prisoner is less likely to harm himself in front of others and if he does try, other prisoners will intervene or alert staff.
87. This was the initial and correct approach between his arrival on 30.11.2001 and 14:30 on the following day (1.12.2001). At that time, D became hostile and disruptive – quite correctly, I would argue (although this is more a discipline issue) he was probably seen as a potential risk to the other prisoners. It is important to note that location of prisoners in health care centres is often a juggling act – we must not forget that in December 2001 there were many other patients apart from D and their safety also had to be ensured.
88. Taking into account his self harm and disruption he was moved on 1.12.2001 to an anti-ligature cell. This demonstrates that they were still aware of the self harm risk but felt that he could not be managed any longer in a ward environment. This managed the risk over the next 36 hours but D was still able to self harm on 3.12.2001 and also obscured his hatch to further frustrate observation; and so a further attempt was made to locate him back in a ward. D was tried again in a ward location but this too was brought to an end when the next day he was seen as hysterical and uncooperative (4.12.2001). It is difficult to be certain of the rationale behind the next move but this is likely to be the risk that he presented to the other prisoners and also that his self harm could not be contained.

89. The next move was into AS3 and I would argue for the same reasons as the earlier move to an anti-ligature cell i.e. being aware of self harm but also reducing the risk to other prisoners. However the move was short lived as D kicked in a panel – also he is seen to be paranoid and continues to threaten to self harm.
90. This brings in the next and only logical choice – managing him on 1:1 observations. I remain unclear as to where this was – the potential choices seem to be a gated cell or a normal cell. The latter is very difficult as it entails making continual eye contact through a small hatch which is at head height. Practically this is difficult.
91. 1:1 observations, in my experience, have both positive and negative aspects. They are overall a ‘one size fits all’ solution but usually manage the risk. They do not necessarily address the risk very well. One would expect that nurses or officers undertaking the watches would lead to greater interaction – in my experience this is not always the case and as has been commented on in the documentation, staff do not interact as much as they should and also do not tend to document well, details around the watch. 1:1 are also problematic in that, cost aside; they can be sometimes difficult to stop. 1:1 watches tend to differentiate and isolate a prisoner from the other prisoners. Nevertheless they can be a useful measure in the short term.
92. Quite correctly the 1:1 watch was brought to an end. This appears to be after the case conference on 10.12.2001 and one would assume after a discussion of the risks. In the next few days there was a gradual and careful reduction of his watch – this demonstrates that they wanted to reduce his watch but did not want to abandon it. It shows that they were being cautious and measured in their approach.
93. The limited information available only allows us to speculate as to the level of meaningful interaction, though I believe it would be wrong to assume that none took place. It also does not take account of some of the other principles of addressing risk, that of association, support and interaction with other prisoners. I note that during his time in HMP Pentonville there is mention of using listeners and The Samaritans but no particular record. In my experience, the lack of records for these groups is not uncommon. In addition to multiagency working, the use of Samaritans and Listeners was a component of the strategy, ‘caring for the suicidal in custody’ and the F2052SH form. It might be wrong to assume that he was not seen.
94. After the case conference above, the multidisciplinary team was considering discharge; they had concluded that D did not have a mental illness and could be moved out of health care to the main prison. Correctly, they were aware of risk and planned to continue him on the F2052SH and use this to convey risk and frame his management – this is one of the purposes of the F2052SH, ensuring that wherever D was to be located they would be aware of risk. This demonstrates once more that D, and the risk that he presented, was being discussed and considered. I note that there were a number of case conferences; Dr Yisa in his interview with Carol Draper indicates that it was a team approach and that other agencies such as probation were present regularly. (Draper report: Bundle 4, Section 8, Page 5). I note also the criticism that D was not present at the case conferences; although prisoners must now be invited to attend ACCT case reviews, in case conferences for those on a F2052SH

in 2001 it was desirable but in my experience the healthcare centre and residential areas of the prison vary in their ability to achieve this. This may have occurred for a number of different reasons.

95. The next event was of course the hanging attempt on 13.12.2001. This took place after the case conference – it is difficult to be certain as to whether the outcome of the meeting was communicated to D, it is possible, but the short timescale means it is less likely. The hanging attempt came very much ‘out of the blue’ and is a further demonstration of the impulsive nature of D. D had demanded (perhaps unreasonably so) medication to sleep during the day. This occurred prior to his appearance in court the next day and this may be the explanation behind his emotions and mood that day. Finding that no doctor was around to respond immediately, he became disruptive – this demonstrates in my opinion, those aspects of his personality that are expressed in behaviour i.e. anger, a low tolerance to frustration and an impulsive response. I would argue that containing him back in his cell further exacerbated his anger and frustration and led to the self harm/suicide attempt.
96. In contrast to the later hanging; this was in response to his needs not being met, as he perceived them. It is not appropriate, in my opinion, for patients to have medication to sleep during the day. The hanging that resulted shows how little D was able to tolerate frustration of his needs and underscores his unpredictability and impulsiveness. After the incident, his management changed once more. In essence this was to manage the risk by moving him to an anti-ligature cell, reducing items and opportunities for self harm. They also appear to try to address the risk by referring him to the Samaritans and probation. It is interesting that they did not put him back onto a 1:1 watch. The judgement seems to be correct as there is more limited self harm over the next 13 days – there is a head banging incident on 16.12.2001, a threat on 25.12.2001 and two other expressions/events which indicate the risk, however overall for almost the next two weeks the risk was seen to be reduced.
97. After his court appearance on 14.12.2001, D was quite settled and interacting with staff and prisoners. D head banged on 16.12.2001 and the risk was addressed by talking to staff. D remained in the minds of the team during the case conference on 18.12.2001. By retaining D in the health care centre demonstrates that they believed that D did not have a mental illness but nevertheless felt that his risk would best be managed by maintaining him in the health care centre and on a 15 minute watch.
98. Exploring events of 27.12.2001 is complex. In contrast to the first week or so of his custody, the preceding two weeks had been much less eventful and D was probably seen as a lower risk. Two days earlier, D had called out that he was going to die that night. This was of course Christmas Day – most staff and clinicians who work in prisons have greater concern over the Christmas period as this is a time when prisoners think more about loved ones. I note that after he called out that he was going to die, is the comment that he ‘would not elaborate.’ It is possible to interpret that this was an attempt to get him to talk and although not successful demonstrates that an attempt to address the risk was probably made.

99. In the morning of 27.12.2001, there is reference to items being found; although it is postulated that they could have been found in other cell(s), Carol Draper's report concluded that they were found in D's cell.
100. Nurse Chikuku's actions that morning demonstrate cognisance of the risks that D presented. Firstly she was cautious in ensuring that D did not retain the razor or used it inappropriately, secondly she saw obscuring the hatch as a risk and took action to address it.
101. Officer Leane facilitated a phone call. This demonstrates that attempts were being made to address risk. In some similarity to the events on 13.12.2001, when D was frustrated, it led to behavioural disruption. Despite this the staff agreed to facilitate the phone call even though this was to a mobile phone, which at that time was more unusual than it is now. Overall it should be considered an act of beneficence. This again demonstrates that the actions were taken to address risk – the officers could have recanted on the earlier promise in view of the destruction. To have declined would likely have inflamed matters further and furthermore though they were potentially aware of the subject matter, there is no indication that the officers (like D) had any expectation of the outcome of that call. The call was allowed; I note that in the live notes, that Officer Leane, believed that he allowed him 10 minutes to calm down. This could be interpreted as a sensible approach in allowing him to calm down before he comes out but perhaps also to make the phone call more productive.
102. The events after the phone call remain cloudy in their timescale. Officer Leane had originally been horrified to consider that D's daughter had died. Afterwards he discovered that she had been taken into care. D was returned to his cell and then he communicated the risk to Officer Hayward (who entered the information in the observation book). This demonstrates awareness of risk and possibly managing risk.
103. My understanding of the events is that Officer Leane did not communicate the news to Nurse Chikuku. There is some contradiction in the comments from Nurse Chikuku in that firstly she had said that D did not appear any different using the terms 'appeared the same as the morning' but also that he did not want to speak. The fact that he did not want to speak indicates that there was a difference. In any event the crucial aspect of this is that she tried to talk and engage with D and also in the Draper report that she 'went in.'
104. It is obviously speculative but if the news about the phone call had been communicated to Nurse Chikuku, what might have happened? The way to address the risk would have been to talk to D; there seems a good possibility that D would not have wanted to talk.
105. In summary, I believe that overall, the approach to managing the risk that D presented is reasonably logical and demonstrate a specific approach to D – this could only occur after consideration of the issues and risks. I did not feel therefore that this was casual – D was clearly central in the thoughts and assessments of the various members of the team on a number of occasions; also this must be seen in context to other prisoners. Although this review and inquiry is about D, he was not the only

prisoner; there were a large number and turnover of other prisoners some of whom would present similar challenges. In terms of the risk surrounding the final event, his reaction is clearly related to an external factor rather than something inherent in the prison. It is worth noting that staff probably had the perception that D's risk was being managed and was coloured by threats and his behaviour. In my experience responsive management is quite often a feature of prisoners who manifest a combination of disruptive behaviour and self harm.

106. Assessing how the service addressed the risk is more complex. Within his time in HMP Pentonville there are clearly points where this has been addressed, thus looking at the information there are small kernels of information which indicate that this has happened. One area that needs to be examined is the role of psychology and psychiatry in this process.

### **The role of psychiatry and psychology the care of D**

107. 2001 reflects an interesting time in prison health care. At that time, whilst The NHS had been present in prisons for some time, the prison medical service was still a major force. HMP Pentonville was reasonably typical of prison medical services at that time. Like many prisons, services had evolved historically with many components as new heads of health care and governors had supported various initiatives. The end result was a mosaic of parts rather than an integrated whole.

108. A few years earlier the seminal discussion document, "Patient or Prisoner" (please see attached), had been published and in March 1999 the government responded with a joint publication between The NHS and The Prison Service; 'The Future Organisation of Prison Health Care.'

109. In the second paragraph of the opening address are the words,

*The Working Group endorsed the existing aim for prison healthcare 'to give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service', and has found that there is some good work being done in a number of establishments in that direction. However, looking at prison health care as a whole, this is characterised by considerable variation in organisation and delivery, quality, funding, effectiveness and links with the NHS. No two prisons could be regarded as the same. This situation is largely a product of a historic legacy, ad hoc development, and relative isolation from the NHS. Prison healthcare is often reactive rather than proactive, over-medicalised with health needs assessments being the exception. Lack of direction, poor lines of communication and confused accountability resulted in many instances in less than optimal health care delivery. Arrangements for the continuing professional development of healthcare staff were not well established. In general there was no way to monitor effectively the outcomes of care. To address these weaknesses a substantial programme of change is needed. The Working Group recommends that this be taken forward over the next 3–5 years on the basis of a formal partnership between the Prison*

*Service and the NHS with funding and departmental accountabilities remaining broadly as at present.*

110. The document stresses at the beginning that there was an aim to strive for equivalence but it recognised considerable variation across the estate which needed to be changed and improved. This led firstly to a needs assessment at each prison together with the parallel developments of the formation of a policy unit and a task force. The second paragraph comments that this was to be taken forward over the next 3 to 5 years i.e. encompassing and beyond the time that the events of D took place. Thus at the time of D, changes were underfoot but not necessarily complete. The prison structure had just emerged in the recent years from a strong deference to The Senior Medical Officer – historically the SMO was a considerable power in the prison, mainly because their opinions and decisions could have considerable sway and effect.
111. There are some themes to pick up. Locally the prison had experienced considerable clinical and managerial change. Traditionally the health care centre had been the centre of the empire that was the Senior Medical Officer. He had headed up the department and had both a clinical and managerial role. Not uncommon at around this time, the prison introduced a different management structure. National and London prisons varied as to whether the individual had clinical experience or not. There was obviously a considerable change in the landscape of the health care unit and in addition to being within an unsuitable area had a number of discipline officers thrust amidst the other health care staff. It is clear to see that some tension existed but it is possible to give this too much importance and does not necessarily mean that clinical care was impinged upon or compromised.
112. HMP Pentonville did not have an SLA (service level agreement) for psychiatry services and though this seems unusual now, in 2001 this was quite common. Like many prisons, HMP Pentonville bought in sessions and continued to increase the number as demand continued to grow. At that point, general adult psychiatry had a very limited presence in prisons and this is reflected in the presence of psychiatry services from the two local forensic psychiatry services based at Camlet Lodge (a medium secure service in Chase Farm) and The John Howard Centre (a medium secure service in Hackney).
113. This was again typical and similar arrangements could be found in other London prisons. In 2001 general adult psychiatry services, who are now increasingly the force in prisons (including now HMP Pentonville), were not particularly interested or involved. Working in a prison was a core component of forensic psychiatry training at that time and also provided an opportunity for experience for their trainees. The local forensic services seemed to facilitate admission to secure beds either within their own service or some of the other lower secure services. There were I believe two other doctors who attended, Dr Hurst and Dr Hagidoff. These were I believe other sessional contracts who probably took on some of the court report work. At any one time, prisons would be expected to provide reports to court at either the magistrate or crown court; this could be quite considerable.

114. The point of stressing this is that at the time there were few options; neither of the forensic services wanted to provide a continuous service, they were not commissioned to do so and could because of the remnants of the prison medical service. They responded to the needs of the Senior Medical Officer by providing more sessions – this tended to be different people rather than the presence of one psychiatrist. The result was some lack of continuity which they attempted to bridge by using a booking system. My own experience of this is that those who present the greatest challenge tend to be seen first. Because there was not an integrated system such as an IT system, success of the system depended upon a chain of systems which largely involved people; therefore there was potential for failure. I note that D had been referred for an assessment by psychiatry on two occasions and this did not take place; there are many reasons which might explain this and I can only speculate on the reasons but I would assume that it firstly reflected the complexity of the process and also I would expect it was not uncommon. Dr Yisa himself comments, ‘because many days the clinics are cancelled due to shortage of staff.’ (Draper report: Bundle 4, Section 8, Page 7). One aspect that might be relevant is that the IMR was often not around.

115. I note that considerable importance has been given to an assessment by a psychiatrist. There are two issues to consider here, firstly whether this was crucial and secondly if he had been seen would this have made a difference?

116. I have outlined the above issues to highlight that mental health services were very much an adjunct to care and thus although they were needed in certain patients the medical service at the prison had to continue to operate whether mental health services were present or not.

117. I note that Dr Yisa’s comment in the Draper report (bundle 4, Section 8, Page 4)

*‘so it was an emotional psychological problem rather than a psychiatric illness, so it’s not like he’s [?] schizophrenic or [?] psychotic, he was having an acute reaction to...an emotional reaction to an ongoing thing. He was somebody who needed psychology and counselling rather than psychiatrists and section, although I think my advice was a referral to both of them, stressing one, psychology.’*

118. As I commented earlier, I feel it is unfair to dismiss Dr Yisa’s viewpoint; he remains a medical practitioner who would be able to recognise mental illness, he had seen the patient on a number of occasions and importantly he had experience of working in prisons. Dr Yisa also weighed up the psychosocial issues and earlier in the same paragraph he comments on the relationship of D’s presentation to these issues:

*‘Yes there were incidents, intermittent incidents in between of self harm but it was all the time although he complained of voices in his head, it was all the time he was upset about the separation from his family and the fact that he may lose his kid.’*

119. As I have commented earlier, although I would use different language, I believe that Dr Yisa is correct in his assessment and formulation of D. In the same context counselling and psychology would have been a good strategy. Weighing up why he had mentioned psychiatry is probably a reflection of firstly requiring confirmation that D did not have a mental illness and secondly some sense of desperation to address the marked behavioural problems and self harm that were evident in the earlier part of his remand. You will note that requests and referrals to mental health services were very much part of the earlier period in custody. Perhaps as the crisis had largely passed the importance and desirability to see a psychiatrist had also waned and it was felt that their time could or would be better occupied with other patients who were in the throes of other crises.
120. Dr Yisa did try to reduce arousal and used Chlorpromazine to this effect. There seems to be some confusion about the role and choice of this drug. Chlorpromazine is an anti-psychotic and has been around for some time. It has also in the past been known as a 'major tranquilliser' and even now within the BNF (British National Formulary) it is indicated as being used for the 'short term management of acute agitation, excitement and violent or dangerously impulsive behaviour.' Chlorpromazine is a good choice with the management of D. Having just completed a detoxification, I would have reluctance to prescribe more short term sedative drugs such as diazepam – these have the potential to cause dependency and to prolong withdrawal and cloud when it is complete. Chlorpromazine has sedative properties and is quite a useful medication to use; its use has waned considerably in recent years. I note that Dr Yisa stopped prescribing this later and this is probably related to its potential to cause extra-pyramidal side effects or dystonic reactions as was seen when D experienced 'lockjaw.' I wondered also whether Dr Yisa had concern about D's use of prescribed medication and wanted to restrict this – the issue of medication seems to be highly important to D as when he demanded medication just before the hanging attempt halfway through his time in custody.
121. I note of course that D was seen by psychology on 18.12.2001; following their referral. The referral was dated 5.12.2001 and completed by Dr Ranaweera. The diagnosis and reasons for referral are, alcohol abuse, past history of mental illness (but adds query diagnosis) and added that he had been referred to St Clements Hospital in the recent past; he also notes the presenting problem as self harm (adding that he is on a F2052SH form), had violent behaviour and had smashed two cells. He also notes at the end that he has had relationship problems and feels that he should have the urgent attention by clinical psychologist and for counselling.
122. As Dr Halsey comments, the prison could make direct referrals to psychology; this was unusual and normally psychology services were accessed through a filter. Interestingly the newer proposals of primary care led mental health services in the last year or so return to this model. Of note in the Draper report is that a referral to psychiatry was recommended but there is less detail as to why. There is no reference to the reasons or any recommendations in his letter back to the prison following the assessment. Dr Halsey later postulated that this might reflect that a parallel process might have been in operation. If such a referral had been desired by Dr Halsey, I would expect that this was again to exclude mental illness and assist in the

management of D. His own assessment does not actually offer any advice about management and thus is of limited value to the prison health team. In his later interviews with Stephen Shaw, Dr Halsey comments that D was a complex case but that the issues he presented with were ‘bog standard.’

123. I have tried to consider what would I have recommended had I seen D prior to his hanging on 27.12.2001. It is firstly important to note that it would have depended upon when I saw him. Thus my management would most likely have been different depending upon when I saw him. For instance, if I had seen him in the first 8 days I would have aimed to reduce arousal and minimise the risks of self harm or suicide. This could well have included using a drug such as Chlorpromazine and perhaps also a benzodiazepine though I would be cautious for the same reasons I have outlined already. I would also try and explore the reasons behind his behaviour as Dr Halsey would have done later. As I noted earlier there was already an awareness of what were the reasons so this would not necessarily have been a revelation. As I was not employed by the prison, the overall management of risk would have remained the responsibility of the prison. On balance I do not see that my intervention and assessment would have changed the management much. One should not underestimate the importance of time – it is not uncommon for prisoners to adjust in this way to prison and the overall pattern of behaviour and risks associated with D is very common, that of an initial period of distress with accompanying emotional, behavioural and biological features which gradually settles. Thus if I had seen D around the time of Dr Halsey or indeed any time after the first 8 days, I would probably have concluded that D had settled but remained a degree of risk. This is reflected statistically in the frequent finding that the risk of suicide and self harm is increased in the first month of custody.

124. Overall, in my 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 27.12.2001. I have great doubts that it would have reduced the risk but probably moved it around in a different way. The latter hanging attempt was clearly an impulsive action which took place shortly after receiving bad news. A psychiatric assessment or even treatment with any form of medication would not have prevented D from feeling the way that he did.

125. In my own service we have had for around 9 years a dedicated mental health team who are in partnership with the prison. We would expect that a patient is seen within 24 hours of admission to the health care centre by a psychiatrist (if they were there for mental health reasons). This was and is a very different arrangement to the service at HMP Pentonville where psychiatrists were present on a sessional basis. I stress this because although many services are now similar to our own, in 2001 our service was highly unusual – the type of service at HMP Pentonville was much more the norm.

### **Equivalence**

126. I was very concerned and dismayed by some of the sweeping statements and generalisations made by Professor Rogers in the final paragraphs of his report

(paragraph 79 to 82). Despite many studies (including government commissioned ones such as the ONS study) the NHS has continued to underestimate the full reality of prison health. Professor Rogers does not take into account the high morbidity, risk, complexity and reality of delivering mental health care in prisons. It represents once more the consistent under-appreciation by the NHS of the enormity of the challenging environment that prison staff face and simplifies the issues.

127. Continually the issue of equivalence has been raised as though this should have been achieved. My own service has been in existence for 9 years and in 2001 we won an NHS Beacon Award for the quality of our service (the first and I believe only award for a mental health service operating in a prison health care centre); additionally we have one of the lowest suicide numbers in London prisons in the last 10 years. However, I would not consider in any way our service demonstrated equivalence to the NHS and I am aware of no examples within the prison estate that can claim this to be so. Criticisms remain within for instance ongoing Inspectorate Reports which continue to identify health care as problematic. This is certainly the issue in the document prepared by the British Medical Association in 2004 – ‘Prison Medicine: a crisis waiting to break.’
128. How can equivalence be claimed when there remain large numbers of mentally ill prisoners throughout the prison estate who are awaiting a bed within the NHS? Many of these patients are insightless, psychotic and without medication as they are outside of the protection that the mental health act provides. At any one time in London there are around 70 to 80 prisoners of this type.
129. The NHS and now PCT’s continually try to consider prison health using the community resources as their reference point. Many continue to consider that health care centres are equivalent of a ward in a psychiatric hospital – how can this be so when one considers staffing levels, a mix of medical and psychiatric conditions and the full range of security challenges? Health care centres are not hospital wards, they are what they are, prison health care centres. John Reed, the medical inspector for HM Inspectorate of Prisons in 2000 commented, ‘Prison healthcare centres, although commonly called hospitals, are not like NHS Hospitals but more like sickbays with primary care cover.’ [Inpatient care of mentally ill people in prison: results of a year’s programme of semi-structured inspections. *BMJ* 2000 April 15; 320(7241): 1031-1034]. It is from this point that we must ground ourselves in reality and consider what could have been done with the resources available in 2001.
130. The fact that prison health does not demonstrate it achieves equivalence does not mean that it is substandard; in reality it means that it is different. Indeed there are many things that the prison does better than the NHS. Most of us would consider seeing a dentist on the NHS quite challenging. Prisoners can see a dentist relatively quickly, as they can see an optician and other secondary services. They have remarkably quick access to drug and alcohol services and particularly receiving treatment such as a detoxification programme. Considering also the issues surrounding primary care at the moment in the community and which have been present for some years. As I have argued already, medical officers in HMP

Pentonville represented primary care. Looking at the events in 2001 D was able to see a GP/medical officer within a few hours of arriving at the prison.

131. Although I would argue that seeing a psychiatrist is probably not the issue, let us look briefly at the differences in accessing psychiatry services between the prison and the NHS. As Dr Ranaweera commented, it was unusual not to have seen a psychiatrist within the 4 weeks that he was there.

132. In the third quarter of 2001 (i.e. covering the period of D incarceration in HMP Pentonville) NHS statistics reveal that across The NHS, psychiatry services saw 3,852 referrals from General Practitioners. Of these total number of referrals, 1,885 waited for between 4 to 13 weeks to be seen i.e. 49%. A slightly smaller number waited under 4 weeks – 1,639 or 42.5 %. This latter figure does not inform us where in that 4 week period they were seen. In other words, in comparison to the NHS, and this seems to be the thrust of the equivalence argument, the majority of patients referred from a GP to mental illness services were seen somewhere between 4 to 13 weeks and therefore shows that the referral to psychiatry services in HMP Pentonville was at least in accordance to the rest of the NHS. One cannot have it both ways, either this is approached on equivalence grounds or not. In terms of equivalence of referrals to the NHS then the fact that D was not seen within three or four weeks is entirely in keeping with the NHS.

#### **What could have been done?**

133. This is obviously an area which there will be different opinions and additionally is based upon the wisdom of hindsight. These will be additional to those utilised by HMP Pentonville and will weigh up the benefits and practical aspects. I would stress that this is not entirely a medical issue and more an organisational one to which my experience may provide some clarity.

134. In 2001 the appropriate tool of management for those who were at risk of self harm was the F2052SH. It is beyond the scope of this report to evaluate its effectiveness nationally or locally. Some of the issues around D reflect the shortcomings of the F2052SH. Unlike the ACCT form it did not guarantee the participation of the individual. The ACCT serves to draw the prisoner in and inherently continues to re-evaluate and re-design the risk management. My overall view about the F2052SH was that it tended to spread risk and was particularly problematic in health care centres where there was in addition an ongoing and sometimes competing medical record.

135. Being in a gated cell and on constant watch on 27.12.2001 would have prevented the suicide attempt. Overall I would postulate that this would have been the only guaranteed action. It is important to note that such a restrictive regime introduces another facet - that of removing those aspects that might make life tolerable in a prison i.e. a restricted regime comes at a price. How one would get to a constant watch is a different matter. I do not think that it would have been correct for D to have been on a constant watch throughout, I have already demonstrated that D was at a lower risk in the two weeks beforehand and arguably did not justify such measures.

Constant watches have to stop at some point and the process of reducing observations beforehand seems to demonstrate a measured response to risk.

136. The issue of being put on a constant watch after the phone call on 27.12.2001 is a different matter and quite complex. As I have understood the documentation, Senior Officer Hayward, who was of course present at the time, was clear that he had the ability to institute a constant watch if this was required. Greater clarity would be essential but this is unlikely to have occurred without some form of discussion and involvement of D. Thus it would require Officer Leane to discuss this with Senior Officer Hayward ideally and additionally not allowing D back into his cell or ensuring that Nurse Chikuku continually observed him in the interval whilst the conversation took place. This then introduces a timescale variable; although there is some disparity about the actual period overall it seems reasonably short. For Officer Leane there was quite a lot to consider and my overall view is that for him to have juggled all these competing issues in a short timescale is expecting perfection. As I have already outlined there is every indication that D would not have welcomed a discussion – such refusal does not in my opinion then make the automatic jump to a constant watch particularly as Nurse Chikuku points out, there was little difference in D before and after the phone call.
137. Overall I would evaluate the topic as having an ideal position, a practical position and a substandard position. In my view, the mechanics of the process around D at HMP Pentonville in December 2001 was very much in the practical position.
138. Perhaps the most sensible option, as Officer Leane was aware of D's poor coping abilities, was to talk to him for a period or to provide a listener there and then – or time out of his cell and interaction with other prisoners.
139. As I have commented earlier, environmental and cultural issues are important but beyond the scope of this report.
140. Could some of the inherent vulnerabilities that D had, been addressed in prison? This is again a large and complex issue which once more is beyond the scope of this report. For the NHS it represents a considerable investment; the results are patchy and services have to be targeted at the right group. At the time of writing an understanding of the vulnerabilities is probably a more practical and typical position that mental health undertakes. In the case of D within HMP Pentonville, although probably not defined in a clinical sense to a great depth by the staff, there are many instances of these vulnerabilities being understood. Thus the terms unpredictable and 'poor copier' has been used by staff; this latter term is potentially seen as a pejorative term but is used in theoretical research quite often to convey the concept and make the issue more easily understood.
141. I have given some thought as to the issue of communication and particularly in relation to Professor Roger's suggestion of a social worker to effectively bridge the gap between social care networks and prison. In my own service we have a social worker who works as part of the mental health team – this has been a recent aspiration. Such a role would not to my knowledge have been present in 2001. The

prison has of course probation officers and it remains unclear as to their involvement in D's management. Dr Yisa has commented that they were present in the reviews – as I have understood the documentation, it does not appear that D's daughter was discussed in a formal way. I would argue that the position is most likely being seen in the wrong direction. Outside social services had probably more of a role to play in communicating to the father (as they would to the mother) in a responsible manner that D's daughter had been taken into care. This indeed might have been under consideration but was pre-empted by the conversation that D had had with his ex-partner.

142. The role of nurses in the health care at HMP Pentonville is another area that has been repeatedly touched upon. The document 'Patient or Prisoner' refers to a confusion of staff where nursing, discipline and health care officers are present in varying numbers. I would agree that health care centres should be staffed by nurses, and ideally permanent rather than temporary members of staff. The prison service has still to this day not shifted from the necessity of having staff to ensure security and this was historically the role of health care officers. It seems to have been overlooked that some of the staff were health care officers and did have some rudimentary clinical training. Additionally there were nurses working in the health care centre but little detail on the exact balance. Currently the role of health care officers is in sharp decline and various PCT's are in the process of removing their clinical role. This was not the position in 2001 and such positions were very much an integral part of health care. Professor Rogers criticises that non clinical staff were involved in the management of those with a mental disorder, but as the ONS study points out, around 80% of all prisoners have some form of mental disorder – thus how could they not be involved in their care? It would mean therefore that prisons would need to be run by nursing staff with discipline staff in support for the small number of prisoners who did not have a mental disorder.
143. I would argue that complex and challenging patients such as D require a multi-disciplinary response which includes a broad range of personnel, including security. Nurses are not necessarily the ideal service to manage this group. Prison officers are actually quite skilled in managing patients such as these in the longer term. A good example would be the close supervision centre in Woodhill. Here some of the most challenging patients/prisoners are managed and work alongside health quite comfortably. The prisoners are very much the extreme in terms of management and mental disorder; they have quite severe personality disorders and of a level often beyond those of the special hospitals. The reader is directed towards the publication, Home Office Research Study 219: Evaluation of close supervision centres. Although the report is critical in some areas it does highlight the need for an approach that reaches across both health and prison.
144. I would finally like to explore a larger issue, that of vulnerable people in prison. Prison has to face an enormous challenge of managing complex, challenging and vulnerable people in prison. I cannot stress enough the reality and challenges of managing such high levels of morbidity in a prison environment. It may be worth considering the risk that courts impose upon prisons in remanding such prisoners into custody. Court liaison services have been in operation for almost two decades and it

is possible that such a service was in operation at Thames Magistrates Court. The fact that D was on a F2052SH and on constant watch for periods, together with an incident of self harm at the beginning, begs the question as to what role the courts have in the risks that an individual presents to himself. Despite three appearances at court and presumably a legal representative who might have introduced this at court, he was repeatedly remanded into custody. It is obviously an enormous issue and cannot overcome the events that are still to come after remand; however the risk has been created by the court by compelling the inherent vulnerabilities of D to interface with those of the prison.

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Approved under Section 12(2) of the Mental Health Act 1983

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