

Prisons and Probation Ombudsman

Investigation no 01/2007

INVESTIGATION INTO THE ATTEMPTED SUICIDE OF 'D' WHILST IN  
CUSTODY AT HMP PENTONVILLE ON 27 DECEMBER 2001

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WITNESS STATEMENT OF DR VASANTHA RANAWEERA

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I, Dr Vasantha Ranaweera *Her Majesty's Prison Pentonville, Caledonian Road  
N7 8TT*, WILL SAY AS FOLLOWS:

1. I am a General Practitioner ('GP') working at Her Majesty's Prison Pentonville ('HMP Pentonville') as a prison Medical Officer since February 1996. I was a member of the medical team involved in the clinical care of patients, in the inpatient unit, during the period 'D' was at HMP Pentonville's healthcare centre (the 'HCC'), in November/December 2001. I was away on leave between 25 December 2001 and 2 January 2002. I was interviewed for the first time regarding the investigation into the attempted suicide of 'D' (by Miss Ali McMurray, for the Prisons and Probation Ombudsman) on 22<sup>nd</sup> September 2006. This was almost five years after the incident and D's Inmate Medical Records ("IMR") and Self-harm At Risk form ('F2052SH') were not available to assist me. After such a great length of time and without being able to refer to his

IMR I have no recollection of 'D' and neither do I recall his attempted suicide on 27 December 2001.

### **Background, qualifications and training**

2. I obtained my MBBS degree from Peradeniya Medical School, University of Sri Lanka in October 1975. During my pre-registration year I worked as a House Officer in paediatrics, and obstetrics and gynaecology, in Kandy University Hospital. I then worked as a Senior House Officer ('SHO') in general surgery and general medicine, and as a Clinical Medical Officer in community medicine in Sri Lanka, before leaving for the United Kingdom in 1981. Since 1982 I was employed in various posts in the UK: I worked as a SHO in geriatric medicine and general medicine in the following hospitals – Grantham hospital, Barnsley hospital, Victoria hospital in Mansfield, and St Ann's Hospital in London. I also worked as a locum SHO in psychiatry for the elderly, and as a locum Registrar and locum part-time Clinical Assistant in the Drug and Alcohol Unit at St Bernard's Hospital and Ealing Hospital. I also worked as a locum Clinical Assistant in psychiatry at Shenley Hospital and Northwick Park Hospital in Harrow. In August 1993 I went for my GP training in South Glamorgan. In 1995 I worked for 6 months as a SHO in obstetrics and gynaecology at Luton Hospital. In October 1995 I applied for a prison service Medical Officer post and I was offered a full time post by the Prison Service headquarters selection board. I have been working as a Prison Medical Officer at HMP Pentonville from February 1996 until the present day.
  
3. In 1986 I obtained my LRCP MRCS (London) and was fully registered with the General Medical Council in May 1986. Following my GP training I obtained my 'JCPTGP' certificate (Joint Committee for Post-Graduate Training for General

Practice) and I passed my MRCGP exam in August 1994. When I started my prison service Medical Officer job in 1996 I was sent for one week to the 'Prison Service Medical Officer Induction' course in Nottingham organised by the prison service. In 1997 I obtained a diploma in Addictive Behaviour from St George's Hospital Medical School; this was funded and arranged by the prison service. In 1999 I obtained a diploma in Prison Medicine from Nottingham University, again arranged via the Prison Service. From February 2005 to August 2005, I completed a six-month 'GP returner scheme', (GP refresher training) at a GP surgery through the London Deanery. Since January 2006 I have been working at a GP surgery in the community, one day a week, as part of my current prison job. This was part of the Prison Health initiative requiring prison doctors to obtain practical clinical experience outside the prison environment. I also obtained a certificate in the Management of Substance Misuse from the Royal College of General Practice in 2006, which was funded by the prison service.

#### **Health Care at HMP Pentonville**

4. In 2001, when a new prisoner arrived at HMP Pentonville, they would go through a process of reception screening. Following routine assessments and security checks by Prison Officers, the prisoner would be assessed by the reception nurse. This involves screening for any physical/mental health problems, drug and alcohol problems, and self-harm/suicide risk, etc. The prisoner would then be assessed by the reception doctor. Following assessment, the doctor would prescribe any relevant medication, and he/she would advise on the most appropriate location for the prisoner. If the prisoner had any physical/mental health problems or alcohol and/or poly drug abuse problems the doctor would write a management plan and arrange admission to the healthcare centre inpatient unit, detoxification unit or refer to the wing GP surgery/outpatient clinic

for follow up. When the prisoner arrived in the HCC inpatient unit the nurses would assess him write up a care plan and carry out the treatment and management plan advised by the reception doctor until the prisoner was assessed and clerked by the healthcare inpatient doctor. The inpatient doctors were those doctors who worked in the HCC and were responsible for the day-to-day management of the inpatients. Following assessment, the inpatient unit doctor would write up a management plan in the IMR and then discuss with the nursing staff. The nurses will update the nursing care plan and carry out the management plan accordingly.

5. The names of new admissions to the HCC were entered in the admissions book by the nursing staff or healthcare officer on duty. There was also a white board in the nurses office with the names and cell location of all the prisoners located in the HCC inpatient unit. Before 5pm, any new admissions to the HCC, (either from reception or from the residential prison wings), would be seen and fully clerked by the 'on-take' doctor for the day. Any new admission after 5pm would be seen and clerked by the 'on-take' doctor on the following day.
  
6. In 2001, the HCC was housed on R wing. R wing was an ordinary prison residential wing converted to a healthcare centre. The HCC was moved there after the old hospital was closed down. R wing was used as a healthcare centre at HMP Pentonville until it was re-located to a purpose built, new building by about mid-2004. R1 landing was used mainly for patients with psychiatric problems and R2 landing was used mainly for patients with physical illnesses. There were single cells on R1 and R2 landing, two semi-furnished cells (anti-suicide, AS1 and AS2), two 'four-bedded dormitories' on R1 landing and an eight bedded observations ward (Ward 3) adjacent to R2 landing. Wards 1 and 2 were closed down during 2001 and turned into a workshop/day centre for the patients

for some time. Later the observation ward was also closed down. The administrative office, IMR room, outpatient clinic consultation rooms, x-ray room, dentist room, the Senior Medical Officer's office and the other doctor's offices were all on R3 landing. Prison officers would bring patients from the ordinary location wings to the outpatient clinic according to the clinic lists. Visiting psychiatrists would assess patients in the R3 landing consultation rooms, doctors offices (when not in use), R2 landing doctor's consultation room, in R1 landing consultation rooms or sometimes, for the inpatient unit patients, in their cells in the HCC.

### **Doctors roles and responsibilities**

7. In 2001, Dr Yisa was the Senior Medical Officer ('SMO') at HMP Pentonville. There were about seven full time and part-time prison Medical Officers/GP's who worked in the HCC inpatient unit, outpatient clinics, the residential wing GP surgeries, detoxification unit, segregation unit and reception. The duty rota was set out by the SMO. There were about two or three doctors who routinely worked in the inpatient unit, in addition to their other duties allocated by the SMO. There were also other specialists who attended the HCC - visiting psychiatrists, clinical psychologists, 'GUM' (genito-urinary medicine) consultant, 'ENT' (ear, nose and throat) specialist, dentist, optician, chiropodist, radiologist and radiographer used to attend for regular sessions. When I first joined the HCC the number of new admissions to the inpatient unit would be equally divided between the doctors on duty on that day. This system was later changed so that one named doctor was responsible as the 'on-take' doctor for all new admissions for a specified day. This would mean the on-take doctor would be responsible for all the new admissions from 5pm on the previous day until 5pm on the 'on-take' day. The HCC inpatient doctors normally start work at 9am until 5pm during the working

week. There was a reception doctor after 5pm until about 9pm for reception work and on call duties. During the night there was always a doctor on call from home. This meant that there was 24 hour medical cover for the prison. In addition Dr Yisa, the 'SMO', was extremely supportive and was quite happy to be contacted by any member of nursing or medical staff at any time of the day or night if they had any concerns about any of the inmates at HMP Pentonville. During the weekends there was a weekend on-call doctor on duty for the prison who would attend the HCC, reception and other residential wings in the prison for any emergencies or consultations.

8. On an average weekday I would start work at 9 o'clock. If I was the on-take doctor for the day I would check the admission book for the names of new admissions. I would also discuss with the nurse (or healthcare officer) in charge of the landing to update me about other patients under my care. If any of the patients need any urgent attention I would review them first otherwise I would go and clerk my new admissions. The clerking process was a comprehensive and lengthy process. A detailed consultation would be undertaken with the patient so that a full medical history is obtained – this would include details about their physical and mental conditions, any drug/alcohol related problems, their personal circumstances and medication/prescriptions. In addition, a full physical and mental state examination would be performed. If we needed to contact the prisoner's GP or an outside hospital in order to get previous medical information and confirm their medication, we would obtain the prisoner's written consent and do so. We would document all this information in the prisoner's IMR and also write up our management plan there. Any referrals to visiting specialists and psychiatrists would be made on the same day. The clerking doctor would also write up all prescribed medication on the prisoner's medication card. On average there were about three to six admissions per day in the HCC.

9. Usually I would go and see other patients after clerking all the new admissions and depending on time constraints. Otherwise all the existing patients will be seen on the daily ward round. The daily ward round consisted of the inpatient doctor going around to see all his/her designated patients and checking on their progress, etc. In addition to my inpatient work I was responsible for the detoxification unit work; for prescribing methadone and alcohol detoxification according to local protocols, after assessment of the new prisoners by the detoxification unit nurses. We also saw 'follow up' patients in the outpatient clinic, that is, prisoners who were discharged from the HCC to the ordinary residential wings of the prison and who needed follow up care. All the doctors had their outpatient clinic appointment books in the HCC administrative ('admin') office and the names of patients who needed outpatient clinic follow up from the ordinary location wings would be entered in the appointment books. When a doctor is away on leave we used to cover each other's work unless locum cover was available.

10. In 2001, doctors would usually have an informal gathering over lunch in Dr Yisa's office on a daily basis. This would be a good opportunity to update with one another and discuss any clinical problems or other day-to-day activities in the prison. We also used to hold twice weekly formal 'ward rounds' in the SMO's office. These formal meetings would be chaired by Dr Yisa and were set up to discuss and review all the patients in the inpatient unit. The ward rounds would be attended by Dr Yisa, all the doctors working in the inpatient unit, the nurse or healthcare officer in charge of the landing, the pharmacist and the probation officer (if available). During these meetings we would discuss all new admissions to the inpatient unit and all existing patients including all those patients on 'F2052SH' forms. We would also review our management plans for all the

prisoners and decide on any discharges and what follow up care arrangements they needed.

### **Changes made to health care at HMP Pentonville**

11. Having worked at HMP Pentonville since February 1996 until the present day I have seen many changes in prison health over the years so it is hard for me to remember exactly what happened and when. In 2000/2001 there were some changes made to the roles of the Head of Healthcare from that of the Senior Medical Officer. Gary Monaghan became the Head of Custody and Healthcare. John Attard was Governor in charge of healthcare and was accountable to Gary Monaghan. Discipline staff were brought in to manage the HCC. There was a shortage in the nursing staff level and we had to rely on agency nurses as well. As a prison Medical Officer I was not involved in the planning or implementation of any of the changes made to the HCC at HMP Pentonville. All these changes were carried out by the senior management team. However, if we had any difficulties or concerns about what was happening in the HCC, we would report these to Dr Yisa.

12. Further changes in 2001 were made due to the introduction of the Mental Health In-Reach Team (the 'MHIR' team). This resulted in changes to the referral system to visiting and forensic psychiatrists and how patients were allocated to psychiatrists. I am not exactly sure when these changes were implemented.

### **Referrals**

13. A prisoner could be identified as in need of a referral to a psychiatrist or psychologist at various times; for example, i) during the reception screening process, ii) following a new patient assessment in the HCC, iii) at the biweekly

ward rounds, iv) during the residential wing GP surgery or v) during the daily segregation round or following assessment by the duty doctor after any incident (including an act of self harm), in any part of the prison.

14. Depending on their mental health problems, alleged offence, nature of charge, risk of self harm and suicide, a prisoner would be referred to a visiting forensic psychiatrist, a visiting general psychiatrist or a clinical psychologist. There were a number of visiting forensic psychiatrists from Camlet Lodge Medium Secure Unit in north London, the John Howard Centre Medium Secure Unit in Hackney and two retired general psychiatrists, (Dr Hajioff and Dr Herst), who attended HMP Pentonville every week on a regular basis. There were also two or three clinical forensic psychologists from Camlet Lodge Medium Secure Unit who attended HMP Pentonville on a weekly basis. We also had two other visiting psychologists for counselling. The visiting psychiatrists would assess the patient, give an opinion about his condition, and provide advice on their management either with appropriate treatment or by facilitating transfer to an outside secure psychiatric unit. Sometimes, if a mentally ill patient required transfer to an outside psychiatric unit, we would invite the consultant psychiatrist with responsibility for the catchment area of the patient to come and assess him, with a view to transfer to a secure psychiatric unit, in their catchment area, under the Mental Health Act.

15. The system for referrals to visiting psychiatrists and psychologists changed when the MHIR was introduced in HMP Pentonville in 2001. I am not sure exactly when this change happened. Prior to the MHIR team, referrals were dealt with as follows: Dr Talat used to allocate all the new inmates from reception, on the ordinary location wings, who needed psychiatric assessment and psychiatric court reports, to the visiting psychiatrists. Referrals for a clinical forensic psychologist were arranged by way of a written referral form, in addition to

documenting in the IMR. The doctor would fill out the request form and put it in the pigeon hole of the forensic clinical psychologist in the HCC administrative office. The psychologist would then simply pick up the form when he was in the HCC and arrange a date on his clinic list for the patient to be seen. The demand for psychologists was high so there was usually a long waiting list of several weeks. Once the patient was seen the psychologist would write up his assessment in the IMR and he would also write to the referring doctor to inform him/her about his findings and advice.

16. Prior to the introduction of the MHIR team, the system for referrals to a psychiatrist were arranged as follows: the referring doctor would write up in the IMR that he wanted the patient assessed by a forensic psychiatrist or a general psychiatrist. A doctor would refer to the forensic psychiatrist if it was thought that a transfer to a hospital may be required, or the alleged offence and nature of charge required this, or their past mental health problems required it. The appointment books for each psychiatrist or other specialist were held in the administrative office (the 'admin office') in the HCC. The doctor would go to the admin office and find out the availability of the psychiatrists from their clinic lists. Then depending on the urgency of the referral, the doctor would ask the admin office staff to enter the patient's name into the visiting psychiatrist's appointment book and the appropriate out patient clinic list. The catchment area of the patient would also affect which psychiatrist the patient would see because the psychiatrist providing cover for north London, for example, should ideally see patients from that area. When the psychiatrist attended the prison all the patients listed on his clinic list would be brought to the outpatient clinic to see him from the ordinary location or from the inpatient unit by the wing officers or clinic nursing staff. For most of the patients from the HCC inpatient unit the psychiatrist will see them in the HCC with the help of the inpatient nurses. The psychiatrist would then

write up his assessment in the IMR. If for some reason the patient in the HCC inpatient unit was not seen by the psychiatrist, this would be picked up by the HCC nursing staff and healthcare officers when we review our patients on a daily basis and also at the biweekly doctor's ward rounds. Once the missed appointment was picked up, the referring doctor or any other member of the healthcare team would rearrange the appointment by discussing with admin office staff and re-listing the patient to see a psychiatrist. At the end of the clinic, the clinic nursing staff or healthcare officers would handover the clinic list to the HCC admin officer. If patients don't attend their appointments they would re-list their names on the next clinic list.

17. There was another safety net in the system because we could always ask Dr Herst or Dr Hajioff, our visiting general psychiatrists, to see a patient urgently, or give a second opinion if a doctor was concerned about a patient who needed an urgent psychiatric assessment. They would carry out an urgent review of a patient while the patient was awaiting an appointment with the visiting forensic psychiatrist. Dr Herst and Hajioff were providing regular sessions at HMP Pentonville and if they saw a patient they would have written up their assessment and advice in the IMR.

18. With the introduction of the MHIR team in Pentonville sometime in 2001 there were changes made to the referral process. The MHIR team introduced a written referral form for both psychologist and psychiatric referrals. The referral form would then be given to the admin office and the Mental Health referral team would allocate the patient to a visiting psychiatrist's clinic list, depending on the urgency of the referral. The MHIR team would be able to see from the clinic lists which appointments had not been kept, so they could re-arrange as necessary. If I had picked up that a patient had not been seen, I would have still have gone to

the admin office and made a request that the appointment be expedited. The key difference in the operation of the referrals was that doctors were no longer in charge of allocating referrals directly. Referrals had to be made on a written request form and routed through the MHIR team.

### **The identification, assessment and care of those at risk of suicide or self-harm**

19. Most of the inmates admitted to the HCC had already been identified as at risk of suicide or self-harm and some of them arrived at reception with an open 'F2052SH' form. The self-harm risk of these prisoners would be noted by the police, or by court staff or escort staff. At reception the prisoner would be assessed by the reception nurse and reception doctor. Following assessment by the doctor if any prisoner was at risk of suicide/self-harm, a F2052SH form would be opened and the doctor would advise regarding the most appropriate location of the prisoner. If a prisoner needed supervision and assessment in the inpatient unit, he would be admitted to the HCC with a management plan for the appropriate level of observations and medication, and with a referral to the visiting psychiatrist/psychologist, if required. Following assessment by the on-take doctor in the HCC, a more detailed management plan would be drawn up with the appropriate referrals according to the prisoner's needs. All patients with an open F2052SH would be discussed during the formal 'ward round' which occurred twice a week. Their level of observation and management plan would be reviewed. The level of risk posed by a particular prisoner would be a factor in deciding on whether they should be admitted to the HCC, the most suitable type of accommodation for them and the most appropriate level of supervision or observations. It would also be a factor in deciding how urgently a patient needed to be referred to a visiting psychiatrist or psychologist.

20. As medical staff we found that dormitory style ward accommodation was a good way to stop some of the at risk patients from self-harming or attempting suicide. It provided an opportunity for prisoners to interact with one another and avoid the isolation of being placed in a single cell on their own. If a prisoner was at risk of self harm but at the same time he was also violent, that would pose a risk to others so such patients would not be suitable for the ward environment. Such volatile patients would be better placed in the AS cells (semi furnished, anti-suicide) or a single cell with the appropriate level of observation. The AS cells were used as a temporary measure until such time as the prisoner did not present a high risk to himself or others and alternative accommodation could be found for him.

21. The level of observation will be decided by the doctor following discussion with the nursing or healthcare officer in charge of the inpatient unit, to reflect the needs of the patient at any given time. Observation levels were also discussed at the biweekly 'ward rounds'.

### **Observations**

22. Prior to 2001, as a general rule, all patients admitted to the Health Care Centre were subject to 15 minute supported observations, carried out by a nurse or a healthcare officer. This means that a patient is checked on approximately every 15 minutes. If I was concerned that one of my patients was particularly vulnerable and likely to attempt suicide or an act of self-harm, one of the management options available to me would be to increase the level of supervision being carried out, to a 15 minute documented watch. This was essentially the same as

the 15 minute supportive watch but a written record is kept of the observations by the nursing staff/healthcare officer. The highest level of observations was a constant watch. This would involve putting a nurse, usually an agency nurse, outside the patient's cell. If the AS cells were used they were gated so the nurse/healthcare officer could watch the patient through the gate; but these semi furnished cells were only used for short periods of time. The nurse/healthcare officer would encourage the patient to engage and interact with him/her and they would constantly observe the patient.

23. The approach in healthcare was one of team work. Either the doctor, nurse or healthcare officer could express any concern about a patient and review their level of observations, increasing or decreasing the level to suit the needs and situation of the patient. I would decide and review the level of observations for my patients during my own daily ward rounds.

24. Decisions to reduce the level of observations on a patient would usually be made by consensus during the formal 'ward rounds' in Dr Yisa's office. If I felt that the level of observations should be reduced during one of my own daily rounds, I would consult with one of the other members of the health care team, (nurses or healthcare officers) to get their input before doing so. In HMP Pentonville if a patient required to be on a constant watch, it would be necessary to discuss with other members of the healthcare team to explain why a constant watch was needed and also to get an agency nurse to actually undertake the observations.

### **Ward rounds**

25. Usually each doctor would review their patients daily and on a regular basis depending on their care and management needs. In addition, there were twice

weekly ward rounds attended by Dr Yisa, all of the inpatient doctors as well as the nurse or healthcare officer in charge of healthcare, the probation officer and the pharmacist. The probation officer would attend if they had any particular input into a patient's case and they were available. These were not hospital ward rounds as such and were more akin to psychiatric unit ward rounds as they took place in Dr Yisa's office to ensure that patient confidentiality was maintained. Each ward round would usually take about 3 hours, depending on the number of patients and the nature of the issues requiring consideration and discussion. Dr Yisa would chair these meetings.

26. The IMR, F2052SH form, nursing care plan and prescription chart would all be considered at these meetings. The purpose of these meetings was to discuss all our patients on the healthcare wing, including new admissions, the care and management of each patient on an open F2052SH form and a general review of each of the other healthcare patients. The discussions about the patients on open 'F2052SH' forms would usually comprise the case 'F2052SH' case conferences. The care and management of each patient would be discussed in detail at these ward rounds. The idea was to pick up on any changes to the patient's status since the previous ward round and discuss whether the patient was being managed effectively. The meeting would usually come to a consensus about what action should be taken next. This would involve making decisions about medication and treatment, levels of watch, the need for referrals and transfer or discharge from the HCC. All outcomes made during these meetings would be recorded in the IMR and nurses would write up in the nurses care plans and carry forward the plans and actions and communicate them to the other members of staff.

27. Once the 'MHIR' team had been set up, the F2052SH case conferences started to be held separately from the ward rounds. The F2052SH case conferences would then be attended by healthcare officers or nurses together with members of the Mental Health In Reach team. I do not remember exactly when this change occurred.

### **The Care and Management of D whilst in Healthcare at HMP Pentonville**

28. I do not remember anything about D as I was interviewed for the first time regarding his attempted suicide last year, some five years after the incident; and I find it very difficult to comment on the care that he received at HMP Pentonville without having sight of his IMR and F2052SH form and also given the passage of time.

29. During my interview with Ali McMurray for the Prisons and Probation Ombudsman, reference was made to a set of nursing notes. I was not shown any nursing notes. The records I was shown were in fact an extract from the Observations Book. These are now produced and shown to me as **exhibit VR1**. The Observations Book was mainly used by discipline staff and so it does not contain any medical details about D's condition or his clinical care and management.

30. I have also been shown a copy of the report produced by Carol Draper for the Prison Service's review of D's attempted suicide ('the Draper report'). This is also now produced and shown to me as **exhibit VR2**. I was not interviewed by Carol Draper before she produced this report. Again without sight of D's IMR, nursing care plan records and his F2052SH form, I find it very difficult to comment further on this report and make any observations on D's clinical care and management

during the relevant time. D's IMR would have contained all the details entered by the reception nurse and doctor, his full inpatient clerking and management plan, his day-to-day clinical care, the biweekly ward round details, and any psychiatric assessment and medication that he received.

31. Having read paragraphs 3.1 to 3.6 of the Draper report, I note that D arrived at HMP Pentonville on 30 November 2001 at 16.25hrs. I have checked a 2001 diary and note that this fell on a Friday. The Draper report states that he arrived with an open F2052SH form and was assessed in reception. He was then admitted to the healthcare centre on an open F2052SH form and given an alcohol detoxification prescription, and placed in the shared ward facility, Ward 3. The report then goes on to say that he was referred for an urgent assessment by medical staff and that a doctor saw him at 5.30pm and referred him to the visiting psychiatrist. I can only assume that D would have been seen by the reception doctor on his arrival at HMP Pentonville and that this doctor referred him to the visiting psychiatrist. Usually arrivals after 5pm are not clerked in the HCC until the following working day. As D arrived on a Friday he would have waited until the Monday to be fully clerked but in the interim the nurses and healthcare officers would have followed the management plan set out by the reception doctor, and D would have been assessed by the weekend on-call doctor if there were any concerns about him by healthcare staff. The Draper report then states that he had a quiet first night but after he threatened staff on the afternoon of 1 December he was relocated to R1. He remained disturbed and at 18.10hrs threatened to self harm with a pencil. The report goes on to say that he remained quiet for the rest of the day and appeared to sleep for most of the following day.

32. Paragraph 3.7 of the Draper report refers to a full history being taken by a doctor on Monday 3 December 2001. I have also looked at the Observation Book entry for that day and it states that I was D's doctor. I assume therefore that I was the on-take doctor who clerked D on the 3<sup>rd</sup> December and became his 'designated' doctor. If I was the clerking doctor, I would have made a full entry in his IMR to set out my assessment and management plan for D. As the designated doctor after clerking the patient, I would have written up his management plan in his IMR and discussed this with the nursing staff; then the nurses would have formulated a nursing care plan and carried it out accordingly. I would have made arrangements for referrals to the visiting forensic psychiatrist and visiting clinical psychologist. Nurses/healthcare officers would ensure that the inmate was seen by the psychiatrist when they come to assess their listed patients in the HCC. I would have reviewed him on my daily ward rounds and discussed him with the nursing staff and I would have discussed him at the formal biweekly ward rounds. In view of his challenging and self harming behaviour, I would have also requested one of visiting general psychiatrists to undertake an urgent assessment and advise on his management while he was awaiting an appointment with the forensic psychiatrist.

33. It is difficult for me to comment on the observations Carol Draper makes in her report about the history taken on the 3 December and the assessment of D without actual sight of D's IMR. I note that D was referred to the visiting clinical psychologist for counselling and the visiting psychiatrist for mental assessment as well as the chaplain, Samaritans and listeners. Doctors would often include these recommendations in their management plans or F2052SH care plans for people with self harm issues. It would often help prisoners to speak to someone who they were not in day-to-day contact with about their problems/issues. If a doctor made such a recommendation it would be entered into the patient's IMR

and F2052SH. It would be the responsibility of the nurses or healthcare officers to follow up these referrals. I am not sure about the process they used. However, the chaplain visited the healthcare centre every morning, so I am sure that he would have seen D if D had wanted to speak with him. Also listeners were available in the prison and so this should not have been a problem to arrange. Similarly, it was straightforward to arrange a telephone call out to the Samaritans.

34. I was shown a referral form to the clinical psychologist for D which was filled in by me on 3<sup>rd</sup> December 2001, and this is produced and shown to me as **exhibit VR3**. This was a written referral form to the clinical psychologist. This is a North London Forensic Service referral form for a clinical psychologist. We only used these forms for clinical psychologist referrals. I can assume that I would have filled in this form during my clerking process of D. Under the heading 'Reason for referral' I have written the following –

*"the triangle abbreviation means 'diagnosis'*

- 1. alcohol abuse*
- 2. past history mental illness (query diagnosis) – referred to St Clements Hospital in the past.*

*History of self harm and on F2052SH. Violent behaviour at times, smashed two cells.*

*Relationship problems – for urgent assessment for clinical psychologist for counselling."*

35. On this form, regarding the degree of urgency, I ticked the box for 'within one week', and also marked it as 'Urgent' on the top right corner. This form would have gone into the pigeon hole for Dr Halsey. There is also produced and shown and to me as **exhibit VR4**, a letter dated 4 December 2001 from Dr Halsey,

addressed to me. In this letter Dr Halsey acknowledges my referral to him and states that he received my referral on the day it was written, namely 3 December 2001. There is also produced and shown to me as **exhibit VR5** a letter dated 25<sup>th</sup> January 2002 again from Dr Halsey and also addressed to me. This states that Dr Halsey saw D on the 18<sup>th</sup> December during his visit to the prison. He informs me in that letter that he had intended to continue his assessment of D in the New Year but was informed that D had since been transferred to the Royal Free Hospital.

36. I cannot now remember if the referral system to the visiting psychiatrist would have required me to write a written referral form or simply to go to the admin office to get the patient listed on one of the psychiatrists clinic lists. However I can only speculate that whatever procedure was in place, that an appointment to see a psychiatrist was expedited. I would have definitely made the necessary referrals and I would have written all the details in the IMR.

37. It would appear from paragraph 3.8 of the Draper report that a further urgent referral to the visiting psychiatrist was made by the duty doctor following an act of self-harm by D late during the evening of 3<sup>rd</sup> December. It is highly unlikely that I was the referring doctor on this occasion because the report states that he was seen at 2115hrs and this is long after my shift ends at around 5pm

38. As in the case of all the other patients in the HCC inpatient unit, we would have discussed D's clinical management on a daily basis with the nursing staff and during the biweekly ward rounds and this would have been documented fully in his IMR and the nurses care plans.

39. Paragraph 6.2.1 of the Draper Report states that D was referred on several occasions to both the visiting psychologist and psychiatrist. The Draper report refers to "entries in the IMR or F2052SH for 30/11, 3/12 (twice), 4/12 and again on 13/12 for the psychiatrist". The report states that "on checking the manual records for referrals to psychiatrists and psychologists", that only two written referrals were discovered to psychiatrists, one dated 4/12 when he was listed to see Dr Akinkunmi on 5/12 (but was not in the event seen) and one on 19/12 when again he was listed but not seen. Dr Akinkunmi was a forensic psychiatrist . I am not sure what is meant by the Draper report's reference to 'manual records' and am not clear what this means. I have already explained how the referral process in HMP Pentonville worked and how this changed when the Mental Health In Reach team was introduced in 2001. I cannot comment on why D was not seen by Dr Akinkunmi. There are various reasons why sometimes prisoners would not be seen by psychiatrists as arranged; for example, clinics may have been cancelled due to a shortage of staff, prisoners may have had to attend court hearings, prisoners may be having social or legal visits, there may be a prison shut down due to an emergency operational reason, or there may have been a shortage of staff to unlock and escort the prisoner to the psychiatrist. These are all general reasons why appointments are sometimes not kept but after six years and without referring to his IMR, I would not know why D was not seen by Dr Akinkunmi in Dec 2001. The reasons for failed appointments would have been documented in his IMR.

40. Carole Draper notes at the end of paragraph 6.2.1 of her report that there did not appear to be any follow up by staff as to why D was not seen by the psychiatrist nor any attempt made for him to be re listed. Again I cannot understand this observation. If D had missed an appointment it would have been picked up by the nursing staff and the doctors or at the biweekly ward rounds, and the details of

why he was not seen would have been written in his IMR and the nurses care plans. Arrangements would have been made for him to have a psychiatric assessment as soon as possible.

41. I find it difficult to understand why D was able to see a psychologist, Dr Halsey, but not a psychiatrist. With my experience of working in the healthcare centre inpatient unit at HMP Pentonville I find it very unusual for an inmate like D not to have been seen by a psychiatrist for almost 3 weeks. One of the two visiting psychiatrists, (Dr Herst or Dr Hajioff) were available in the HCC almost every day. In light of D's disruptive and self harming behaviour whilst in the HCC inpatient unit it is highly likely that myself or another member of the healthcare staff would have asked Dr Herst or Dr Hajioff to see him, at some point regarding his management while he was awaiting to be seen by a forensic psychiatrist. If Dr Herst or Dr Hajioff had seen him they would discussed their assessment with the doctors and the nurses and they would have written up their assessment and management plan in the IMR. If one of my patients had not been seen by a psychiatrist I would have discussed that with the nursing staff to find out why he was not seen and try to expedite the appointment. I would have discussed it fully at the formal biweekly ward rounds and documented all the details in the patient's IMR.

42. From what I have seen of the remaining documents and records, and taking into account D's self harming and challenging behaviour, he would have needed a lot of support and supervision throughout his time in custody. He had been kept in healthcare throughout his stay at HMP Pentonville despite the very high demand for beds. This was the only place where he could receive the appropriate levels of support and supervision and it appears that a great deal of effort went into his care and management to try and keep him safe.

**Changes in operational methods, policy, practice or management arrangements to help prevent suicide and self-harm in Pentonville and other prisons**

43. There have already been some important improvements in managing suicide/self harm risk in prisons. For example, the CARAT (Counselling, Advice, Referral, Assessment and Through care) team (for substance misuse) and the ACCT (Assessment, Care in Custody and Teamwork) programme. It is important to identify self harm risk at an early stage to allow for prompt intervention by psychiatrists and the mental health team. Also early and meaningful interaction with the prisoner is very helpful to prevent acts of self harm during the early stages when a prisoner is acclimatising to the prison environment. Improved facilities to attend day hospitals, and participating in workshops, (for example like art therapy), and other education programmes also helps to assist prisoners to overcome their anxieties.

I believe the facts provided in this statement to be true.

Signed..... K. Panayiotou  
Position..... Prison Medical Officer, HMP Pentonville  
Date..... 7/11/07