

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

WITNESS STATEMENT OF DR MAHAZU YISA

I, Dr Mahazu Yisa of *Woodlands Health Centre, 4 Edwin Hall Place, Hither Green Lane, London, SE13 6NR*, WILL SAY AS FOLLOWS:

1. I am a General Practitioner ('GP') in South London but I was the Senior Medical Officer in the Health Care Centre at Her Majesty's Prison Pentonville ('HMP Pentonville') on 27 December 2001. I can remember very little about D but I am happy to assist the Prisons and Probation Ombudsman with his investigation into the facts and circumstances surrounding D's attempted suicide as far as possible. However, without D's Inmate Medical Record ('IMR') I will not be able to speak to the specifics of his condition or treatment in detail and will only be able to provide general information about healthcare at HMP Pentonville.

Background and qualifications

2. I understand that John Attard has said that I qualified as a paediatrician. This is not correct. I qualified as a general physician. I believe that the staff at HMP Pentonville may have been confusing my background with the background of Dr

Khan, one of my former colleagues at HMP Pentonville. I obtained my Bachelor's degree in Medicine and Surgery ('MBBS') in Ibadan, Nigeria in 1976. The MBBS and necessary pre-registration postings provide doctors with training and experience in all of the key areas of medical practice including psychiatric care and the diagnosis and treatment of the mentally ill.

3. In September 1979, I moved to the United Kingdom. Between 1979 and 1986 I worked in various hospitals as a junior doctor, including the Charing Cross Hospital, London and Wembley hospital, part of the Central Middlesex group of Hospitals. I also worked as a junior doctor in Dewsbury and Mansfield hospitals. During this period, 1979 to 1984, I held training posts in medicine, I also studied for and obtained my membership of the Royal College of Physicians ('MRCP') in the UK. This is a post-graduate qualification which reflects the considerable experience that I had gained in my pre and post registration posts in general and internal medicine and it also involved training in diagnostics, prescribing practices and the known side effects of various drugs. From 1984 to 1986 I worked as a Registrar in general and internal medicine at Kings Mill, Mansfield and District hospitals. It was part of my duty in that post to visit the general psychiatric wards to advise on medical complications during on call duties (one day in three). In 1986 I moved to Saudi Arabia to take up a post as Consultant General Physician.

4. I returned to the United Kingdom in 1988 and worked as a locum doctor for about three months, taking on short-term contracts in various hospitals such as University College Hospital, the London Hospital and the Lister Hospital in Stevenage. In September 1988 I was offered a post as a Community Medical Officer in Leeds. This involved duties such as supervising immunisation programmes, carrying out health checks and running education programmes in schools.

5. I left this post on 19 November 1989 to join the Prison Service as a prison Medical Officer on the 20th November 1989. I was attached to Winchester prison for two weeks as part of my induction course before taking up my first posting, at Her Majesty's Prison Brixton ('HMP Brixton'). I found that there were a number of psychiatrists working at HMP Brixton at that time, but very few generalists. As I was a generalist, my services were in great demand. During this time I developed a keen interest in the proper medical care of prisoners and a particular interest in the care of substance misusers. Senior Managers were impressed with my work and soon invited me to take the Prison Service promotion board exam to become a Senior Medical Officer ('SMO').

6. I passed the promotion board exam and became an SMO at the end of 1991. I worked as acting SMO at Her Majesty's Prison Swaleside and Her Majesty's Prison Wandsworth on a temporary basis, before taking up the post of the SMO at HMP Pentonville on 5 May 1992. In 2001 a Home Office Committee recommended that all prison doctors should be qualified as GPs. Before this time, the required qualification was a postgraduate degree from the Royal Colleges in any area of medicine. I therefore left HMP Pentonville in February 2003, to train as a GP. In 2005 I qualified as a GP and then formally left the Prison Service to join my current practice in South East London.

Training

7. When I first joined the Prison Service and was posted to HMP Brixton, I realised that a lot of the problems faced by prisoners were exacerbated by substance misuse. I became very interested in caring for prisoners suffering from substance misuse and therefore requested the funding to undertake a diploma in addictive

behaviour and substance misuse at St George's Hospital in Tooting. Funding was made available for myself and 4 or 5 other Doctors in the Prison Service. The diploma was run as a day release course, which we attended one day a week over one and a half years. The diploma course provided doctors with a wealth of information about physical and psychiatric assessment and the sociological analysis of dependence and addictive behaviour. The diploma also focused on the pathology of dependence and mental health issues. This is of particular interest to me as some substance misusers have mental health problems before they become drug or alcohol dependant and as such are known as having dual pathology. Other substance misusers develop mental health problems as a result of their dependency.

8. In 2001 I completed a further one-year course in substance misuse and obtained the Royal College of GP Certificate in Substance Misuse. Although this course was in some respects similar to the diploma course I had attended earlier in my Prison Service career, it was an important update and useful for managing substance misusers in a primary care setting.

The Draper Report

9. I attended several interviews with Carole Draper in 2001, as she was the Senior Investigating Officer who was charged with carrying out internal reviews into deaths in custody in the London area at that time. I remember that she interviewed me in connection with the death of SC on 28 December 2001. Whilst she was interviewing me about SC, she also asked me if I would answer some additional questions about the care and management of D. I had agreed to answer any questions she had about D. I did not have D's Inmate Medical Record ('IMR') with me when I attended the interview with Carole Draper. As far

as I can remember D's medical record or treatment card were not available at the interview. I did not have the opportunity to review the transcript of this interview or to sign it. Unfortunately, I do not believe that it provides a complete account of my dealings with D and it appears to contain a number of inaccuracies and significant omissions.

Senior Medical Officer

10. The Role of the Senior Medical Officer ('SMO') had changed dramatically in 2001. Health care was placed under the custody department. John Attard was promoted from acting (discipline) principal officer (PO) to acting governor 5 by Mr Gareth Davies. Mr Attard was then moved from the discipline side to take charge of the health care centre and health care activities as Governor in charge. John Attard reported to Gary Monaghan who was head of custody. The head of custody reported to the Governing Governor (Mr Gareth Davies).

Healthcare Initiatives at HMP Pentonville

11. I was proactive as Head of Healthcare and one of the key concerns for me was to reduce the number of deaths in custody as far as possible. I started the suicide prevention wards with this in mind and also set up the first methadone based detoxification. This method of detoxification was very successful and I was asked to input into the draft policies on the use of methadone for the entire prison estate.

12. I was also keen to improve the provision of specialist care to patients in healthcare at HMP Pentonville. I negotiated the provision of psychiatric cover from Camlet Lodge (a north London medium secure psychiatric unit), John

Howard centre (east london medium secure psychiatric unit), and brought in a number of general psychiatrists. I was also instrumental in offering training for senior registrars/specialist registrars in forensic psychiatry. The prison paid part of the salary of the first such registrar. I also arranged for the John Howard centre (a medium secure psychiatric unit in East London) to provide us with 15 psychiatric nurses every week.

13. The 1999 HMCIP report praised HMP Pentonville for its psychiatric arrangements. HMP Pentonville was noted to have the best psychiatric cover in the country and the highest number of Mental Health Act transfers. The Forensic psychiatrists, unlike general psychiatrists, have more experience of working with and managing mentally ill offenders, particularly in secure settings.

14. If a mentally ill offender is sectionable he can be removed under section 47 and 48 of the Mental Health Act of 1983. These sections do not involve the courts and have the potential of being carried out quickly provided a bed was found in an appropriate, approved, and secure unit. After treatment or stabilization such mentally ill offenders are returned to the judicial system or prison, with or without a recommendation for disposal. There was and there continues to be a national shortage of such beds and/or units. Facilitating access to such units was crucial and HMP Pentonville, as a result of my efforts, had the best arrangements and the highest rates of transfer in the country in 1999.

15. At HMP Pentonville we needed to involve general and forensic psychiatrists, general and forensic psychologists in the management of our patients. We relied on a patient's psychological assessment to assist in the management of the patient. The psychiatrists advised on management, mental health section and facilitate transfers. The active (not retired) forensic psychiatrist with access to

secure beds is obviously most useful. One referral was not more urgent than the other; the two go hand in hand. Patients with personality disorders are not usually sectionable, however we usually relied on the psychiatrists to make these decisions. We did of course provide useful input /information and observations to assist these decisions. The psychiatric nurses and their care plans were also very useful. There were patients with personality disorders and intermittent episodes of psychosis or depression or both. Such patients would usually have substance misuse or dependence problems as well. Advice from the psychiatrists and psychologist is usually solicited and useful for such patients. Day to day management by the experienced prison medical officer is usually crucial. To be honest, we treated all of our patients as having suspected mental illness until they had been fully diagnosed by the visiting specialists. All we did at HMP Pentonville was assess the patient's current state and advise on how those symptoms should best be managed in the short term.

16. From about 1997 or earlier and definitely in place as of 2001 the cover at Pentonville was as follows. During the week days – Monday to Friday, there are two AM sessions and two PM sessions of psychiatric assessments. There were four to six psychology sessions a week. Forensic psychiatrists that visited from Camlet Lodge included Dr's Akinkunmi, Hamilton, Duffield, Williams, Bates and Khattani. Forensic Psychiatrists that visited from The John Howard Centre included Dr's Mary Whittle, Ballakrishna and Neil Boast. General psychiatrist, Dr Herst provided 4 or 5 sessions a week. General psychiatrist, Dr Hadjiouf provided 2 to 3 sessions a week. In addition to these there were at least three or four senior registrar psychiatric sessions a week from Camlet lodge or John Howard centre. I actively encouraged these consultants in training to attend sessions at Pentonville and to prepare court reports as part of their training – under the supervision of their respective consultants of course. Earlier on in 1996/97 Dr

Harry Kennedy had assisted me in securing the recognition of HMP Pentonville for senior registrar/specialist registrar training by the Royal college of Psychiatrists.

Problems in Healthcare at HMP Pentonville

17. During the HMCIP inspection of 1999 I advised the inspectors about the unsuitability of the environment (the Health Care Centre), the lack of cleanliness and lack of purposeful regime and the absence of dedicated senior lead nurses and the chronic shortage of psychiatrically trained nursing staff. I complained to the Inspectors about my disappointment that earlier arrangements with the secure units to contract in psychiatric nurses had been discontinued on financial and political grounds. The HMCIP report WAS VERY USEFUL.

18. The Prison HQ responded to the report by placing the Health Care Centre on Red Light Status. The Prison Governor responded by placing the Health Care under custody. Gary Monaghan became the Head of custody and health care. John Attard became the governor of health care and accounting to Gary Monaghan. The available staffing level for daily duties was reduced from about 23 to a level of 12 to 14. Discipline staff were brought in to be the middle managers on the hospital landing and to manage health care. I was not consulted about any of these changes. Emphasis was placed on keeping the place clean and running a wing type of regime. Clinical and health care aspects in terms of nursing duties and protocols became peripheral – largely ignored. Discipline staff controlled the show and reported to John Attard – Gary Monaghan – governor 1.

19. The health care centre and delivery of health care services was turned upside down. The health care centre became another discipline wing. Senior and junior nurses were frustrated. I offered constructive criticism of the changes. I supported efforts to keep the environment clean and to run a purposeful regime for patients. I advocated that sufficient nurses be allowed for and that they should be allowed to perform their clinical duties under nursing leadership and supervision. I maintained leadership of the doctors. I appealed to the doctors for some understanding. I advised that we continue to do our best for our patients. However, I believe that there was such a great deal of pressure on the senior management to demonstrate change that some of the changes made were implemented too quickly. I was often frustrated as I felt that my experience as SMO was not being drawn on and that I was not sufficiently consulted before changes were implemented.

20. The doctor who was on duty for Healthcare in-patients on a given day would become the doctor allocated doctor for all patients admitted into the Health Care Centre on that day and would be their designated doctor for the duration of their stay in the Health Care Centre. The designated doctor would be responsible for clerking the patient and drawing up a management plan. They would decide who needed to be referred to specialists and arrange the referrals. They would then put their patient on to the next clinic list of the visiting specialist. The nurses would ensure that all instructions are written into their care plans and are carried out – implemented. They would jointly assist the visiting psychiatrist and note any difficulties or observations in their care plans.

21. The existing system was changed without consultation or input from the medical staff. The intention was to reduce the cost of providing psychiatric services. Any savings will then be used to fund the community mental health team. However

changes were being made and yet 90% of the mental health team had not yet been recruited! I accept that under the old system there was some duplication. This was intentional and an important safety net. Under the new system, a patient would be put on a list for a particular psychiatrist. This meant that they could not see anyone else. This system removed the proactive input of the responsible doctor, who had the best sense of how urgent each case was. I explained all these to Carole Draper. I also explained to her about the dramatic changes to the management and staffing profile of the health care department.

Healthcare at Pentonville in 2001

22. In 2001 the Health Care Centre at HMP Pentonville was split over 3 floors of R wing. R wing was never designed to be a healthcare centre and was not as bright or clean or as well equipped as a modern hospital but we did the best we could with the resources available to us. Patients with mental health issues were housed in single cells on the R1 landing. There were formerly two small wards on the R1 landing which we would use to observe the more stable patients, but these had been closed down by the end of 2001 and were turned into an area for cleaners and a workshop for patients where they could undertake art therapy and other therapeutic activities like pottery. There were also two AS cells on the R1 landing. Patients with physical illnesses were housed on R2. There was a close observation ward on the R2 landing, which was known as ward 3. On R3 there were consulting rooms for the visiting specialists such as psychologists, psychiatrists and dentists. My office and the other doctors' offices were also on this landing. I think that the R4 landing was being used for vulnerable prisoners in 2001 and that R5 was being used as a detoxification centre, but I cannot now be certain after such a long period of time.

Doctors Roles and Responsibilities

23. On an average day, Dr's Ranawerra and Khan would work from between 9.00 and 17.00 as in-patient doctors in the Health Care Centre. They would arrive in the Health Care Centre and look at the whiteboard with the patients' details on and then look at the details of the new patients in the admissions book. They would then ask the nurse in charge to give a handover. This would highlight any significant events or incidents relating to their patients and to the Health Care Centre in general. When a doctor leaves for the day he would again give an oral handover to the nurse in charge.

24. The doctors would then go and see each of their patients to check their general well being before clerking the new admissions. The new admissions would be the responsibility of the on take doctor of the day. The clerking process requires the doctor to hold a full consultation with their patient and to take a detailed medical history. This would take at least one hour. After the consultation, the doctor would then have to fill in the patient's IMR and draw up a management plan. This would include prescribing medication in consultation with the pharmacist, determining the appropriate level of observation for the patient and making referrals to specialists for treatment.

25. It would be helpful to be able to show you one of my staffing rotas from this time, but I understand that they cannot be located. To the best of my recollection, a typical rota from 2001 would show that there were three doctors allocated to run GP surgeries for prisoners on the wings between 9am and 12noon, one doctor who was the on-take doctor and one doctor who was the duty doctor. The duty doctor was based in the Health Care Centre but was on call for the whole prison between 09.00 and 17.00. From 17.00 to 19.30 he would work at reception,

Training

31. Due to the nature of the patients on the R1 landing, the healthcare centre staff were well used to dealing with mental health issues as well as those at risk of suicide and self-harm. The Prison Service provided update training in suicide and self-harm prevention for all staff as well as training on the use of the F2052SH. As far as the doctors were concerned, they also attended a week long prison health training course in Leicester once a year. At least one day of this course provided a dedicated mental health update, which covered the management and assessment of the mentally ill. Most prison doctors come from a generalist background, and the majority are GPs. This is why a high level of specialist services need to be available to support the work of the doctors. I understand that nowadays they have a team of psychologists and psychiatrists actually based at HMP Pentonville.

The Self-harm At Risk Form 'F2052SH'

32. When the self-harm at risk form ('F2052SH') was rolled out, I attended a 2-day training session in Cambridge with the then governor of HMP Pentonville, Governor Abbott. This training was to prepare us for the introduction of the new form and processes to be followed. In fact HMP Pentonville was one of the first prisons in the country to get the F2052SH process up and running. I was responsible for incorporating the F2052SH process into the Health Care Centre at HMP Pentonville and am confident that the doctors and staff in the Health Care Centre used the F2052SH system effectively, to identify those at risk, to keep them safe, to address their issues and arrange for appropriate care and management plans in each individual case.

Case Conferences

33. The F2052SH process required regular case conferences to be held on each patient. These would be held in my office, on a Tuesday and a Thursday as a part of the ward round. I would always attend. The patient's doctor would attend. There would also be a nurse there with the patient's IMR. There would also sometimes be a representative from probation or chaplaincy at the case conference as well. Prior to the 2000/2001 changes, case conferences always had clinical input. Kay George, or whoever was in charge of the nursing staff on a given day would decide which nurse to send to each patient's case conference and brief them about the patient's condition and behaviour if they had not experienced this first hand.

34. The F2052SH process encouraged the use of key caseworkers. The idea was that the patient had a nominated member of staff that they could talk to and as far as I can remember this was designed to ensure as much continuity of care as possible. I believe that this was really aimed at prisoners on ordinary location, as they did not have nearly as much input in to their care and management as patients in the Health Care Centre. The nearest equivalent to this in the Health Care Centre was the named nurse system. I believe that this would have been in place in the healthcare centre before the changes of 2000/2001. Kay George introduced this system and dealt with the practicalities so I cannot comment on this in any great detail but as far as I remember there was a designated nurse for each half of the R1 landing.

Accommodation

observations . In these cases the locker will be removed from the cell so that the patient would be less likely to smash it up and cause harm to himself or damage to property.

42. I did not think that these semi-furnished cells were the best way to manage vulnerable prisoners, and to be honest, whenever we had to put a patient into one of these cells the burden on staff was increased and they had to do more observations and fill out more documents. We would do everything that we could to keep patients out of these cells, by interacting with them and try to calm them down and encourage them to talk about their problems, if not to us, then to the Chaplain or the Samaritans.

Observations

43. A doctor would make the decision as to the appropriate level of observations for each of their patients. If any of the doctors were concerned about one of their patients, they could contact me at any time, 24 hours a day, and this was clearly understood by all staff. In 2001 we would usually use agency nurses to carry out 15 minute documented and constant observations. Once the appropriate level of observations had been determined, we would temporarily deploy a member of staff to carry out the observations until agency nurse cover was arranged. It could take several hours from putting in the request to the agency and the nurse arriving at the prison.

44. I felt that constant observations were a necessary evil. They were a temporary measure only as they were very intrusive for the prisoner on the one hand and were not the most efficient use of staff on the other. I much preferred patients to interact with staff and work through their issues constructively. This is one of the

main reasons why I was not in favour of the decision to close ward 3. Removing a patient from a one to one watch was usually a decision that was made by consensus of all the staff present at the F2052SH case conference.

The Suicide Prevention Committee

45. The Suicide Prevention Committee had long been in place at HMP Pentonville. I cannot really comment on how the committee worked as I did not always attend these meetings. I think that it was Dr Talat who attended these meetings as the representative of the Health Care Centre and would feed back to me. The minutes of these meetings would also be circulated to me. As far as I can remember, in 2001 the Suicide Prevention Committee was responsible for matters such as the consideration of suicides and incidents of serious self-harm, the operation of the care team and the training and deployment of listeners. Prior to 2001, it was the SMO's responsibility to write a report following a suicide or serious act of self-harm and submit this to the Suicide Prevention Committee and the Board of Visitors. The Suicide Prevention Committee also took an active role in disseminating leaflets about suicide prevention to prisoners and putting up posters so that prisoners knew what support mechanisms were available to them. They were also involved in liaising with prisoners' families to organise suicide awareness events and open days.

The Emergency Medical Response Team

46. Mr Peter Hayward was a dedicated health care officer. He was passionate about first response to medical emergencies. I supported and assisted him to obtain funding for his trauma course, funding for the training equipment and manuals

and funding for the area wide training of prison staff in the management of emergencies. I am very proud of him and I also wish to thank the Area Manager in post then for his support. Peter Hayward in particular and all the staff at HMP Pentonville deserve praise for the success of the Emergency Medical Response Team ('EMRT') and the lives they have saved..

Care and Management of D whilst in Custody at HMP Pentonville

47. The allocated medical officer is usually more closely involved in the day-to-day management of his/her patient – such as D. The SMO will usually be involved during case conference, giving a second opinion, assisting facilitation or as a result of a complication. It is difficult for me to talk in detail about specific cases after such a great length of time, without being able to refer to medical notes.

48. I must stress that Carole Draper's report should not be treated as a substitute for D's medical records when it comes to considering his clinical care and management. In order to get a full picture of D's mental and physical condition and his care and management whilst at HMP Pentonville, I would like to see his prison medical records, GP records, and records from external agencies that had provided any psychological or psychiatric support in the past. These would explain the care that he had received in the community and whether any diagnoses had been made. It would also tell me what medicines he had been prescribed in the past and what medication he should avoid. I would also expect to see his core record, IMR, Prescription Chart and F2052SH.

49. The IMR is a diary of the daily actions taken with regards to a patient by doctors and visiting specialists. The IMR would have contained the initial management plan completed by the doctor on reception, the full medical history taken by the designated doctor during the clerking process and their management plan. There would have been full notes in D's IMR about his mental state and level of vulnerability, how and when the decisions to refer D to specialists were made, and the difficulties associated with this would also have been carefully documented here. Once a patient had been seen by a visiting specialist, their advice regarding the patient's diagnosis, management and appropriate disposal would also be written into the IMR.

50. The patient's prescription chart would provide a comprehensive list of all the medication that the patient had been given as well as a note of medications which should not be administered, if for example the patient was a former addict then you would not be able to prescribe drugs with addictive properties. There would also be a full record here of the detoxification treatments given.

51. The Core Record (known as the 'F2050') is a record of each prisoner's time in prison. It contains the warrant for their detention and a list of their previous convictions. It is used by the prison officers as a discipline record. I would usually arrange for the section that dealt with the prisoner's previous convictions to be copied and put into the IMR as this information is helpful to staff in understanding a patient's background and is of particular importance for the forensic psychiatrists when they are preparing their reports.

52. As part of the healthcare clerking exercise, we would ask new admissions to the healthcare centre to sign a form of consent for the release of their GP records to their designated doctor. We are only able to obtain consent in approximately 20 –

30% of cases. In the vast number of cases, we would also receive general medical or specialist psychiatric reports prepared for the court as part of the individual's trial. These reports would usually arrive at the prison with the prisoner and was common amongst both remand and sentenced prisoners. In addition we would also have our own records of those who had previously spent time in healthcare whilst in custody at HMP Pentonville and also had access to medical information held by other prisons. All of these different types of information would invariably deal with the patient's medical history and so would help us in deciding and how a patient should be supported and cared for in the healthcare centre. I do not recall whether we had access to D's GP records, court reports or reports of healthcare he received during his previous spells in custody at either HMP Pentonville or at other establishments.

53. The Draper Report is very vague about the clinical management of D. In the absence of the IMR and the F2052SH form and other clinical documents I am not able to comment further on it.

54. I remember clearly that I talked to Carole Draper in some detail about mental health issues and about personality disorders but these conversations are not reflected in the transcript. I thought that D had mental health problems of the personality disorder type. The forensic psychiatrist was to advise as to his mental state, whether or not he was sectionable. To my mind, the issue was whether he was having a psychotic breakdown as an acute reaction to the emotional stress that he was under. We wanted D to be referred to both a psychologist and a psychiatrist, as we wanted to see what advice we could get as to his management from both sources. It is not correct to suggest that we favoured psychologists to psychiatrists at HMP Pentonville. It is just that we favoured a team approach and we wanted to get patients seen as soon as possible so that if

a patient could be transferred out of HMP Pentonville, then arrangements could be made as quickly as possible.

55. The entries in the Observation Book from November and December 2001 are now produced and shown to me as **exhibit MY1**. I must stress that these are no substitute for D's IMR. The Observation Book was a general document completed by the Prison Officers and so clinical notes such as care and management cannot be found here. These would have been recorded in D's IMR, nursing care plans and F2052SH by his doctor and/or nurses.

4 December 2001

56. The adjudication reports for this incident are now also produced and shown to me as **exhibit MY2**. These show that D was moved from Ward 3 to AS3 following an act of self-harm. In AS3 he kicked the toilet unit until it fell apart and was placed on report. He was moved to a healthcare cell. I do not have any real memory of the incident on 4 December but what would usually have happened if a patient had acted in this way is that his responsible medical officer would have come to see me, expressed their concern and asked for my advice. I would then have gone to assess the patient. From the entries made in the Observation Book and in the adjudication reports, it appears that I would have found D to be agitated and distraught and talking about hearing voices. He would probably have been on an alcohol detoxification at this point and so this could also have had an impact.

57. D was asking for medication to stop the voices in his head. I do not think that he was really aware of what he was doing. On assessment, I found that D needed

the emergency sedation to prevent him harming himself. I have the impression that D might have been banging his head at this time. Continual head banging is very dangerous and requires a careful examination of the patient. There is always the risk of the patient sustaining a head injury in such circumstances. Careful observations are usually made before and after sedating such a patient.

58. I wish that I had copies of the HMP Pentonville Healthcare internal protocols in force in December 2001 as these explain what the procedures to be followed in such cases were. I understand that these cannot now be located and may have been destroyed after I left HMP Pentonville. There was an internal protocol to cover each of the key tasks carried out by doctors and nurses in the Health Care Centre. When Kay George came in as matron, she was responsible for updating these policies and I seem to remember that she allocated a specific protocol to each nurse so that they were responsible for updating it on a regular basis. Under this protocol, it needed the opinion of the SMO and another doctor to administer emergency sedation. Dr Ranawerra would therefore have been present and either one or both of us would have recorded our actions in the IMR. If I have administered a sedative by injection, I would have had the patient in the health care centre and made sure that he was kept on close watch and given adequate fluids.

59. The emergency sedation referred to in the reports would have been a combined sedative and anti psychotic. The purpose of administering emergency sedation is to stop a patient from harming himself or others. Once a patient has calmed down, he is able to discuss the issues he is facing with staff, who can offer constructive advice about how to cope with his issues without resorting to self-harm. Where a patient appears to be mistrusting of prison staff, it is common that we refer them to the Chaplaincy or the Samaritans as they are seen as much

more independent than some of the other prison staff, and of course, anything said to the Samaritans is treated as being in absolute confidence.

60. Anyone who is ill enough to get emergency sedation is treated as requiring urgent assessment by specialists. I remember feeling that D was very disturbed and I was not sure that he was always aware of what he was doing. He needed to be looked after. In line with our internal protocol, anyone who was given emergency sedation was to be subject to close observations at least once an hour to make sure that they did not become dehydrated and that they were breathing properly. The case conference on the 4 December would have been held right there on the landing outside D's cell as an immediate response to the act of agitated and disturbed behaviour which necessitated the emergency sedation.

5 December 2001

61. I understand from paragraph 6.2.1 of the Draper Report that D was listed to see a forensic psychiatrist, Dr Akinkumni on 5 December. However, he was not seen. The Draper report does not explain why D was not seen and there could be a number of reasons why he did not see D. However, I note from paragraph 3.12 of the Draper Report that on 6 December D was due to have a legal visit but that this was cancelled as he was not feeling well. It is stated that physical observations were ordered on D on an hourly basis. As I explained at paragraph 79 above, this was standard practice after having administered emergency sedation. It is therefore likely that D did not attend his appointment with Dr Akinmuni on 5 December as he was still feeling the effects of the emergency sedation that I administered on 4 December.

62. I find it highly unlikely that after D did not see Dr Akinkumni on 5 December that this was not followed up by Dr Ranaweera. I feel able to say this as she was so meticulous about her record keeping and it was her practice to really push for her patients to be seen by any of the available specialists.

10 December 2001

63. In the transcript of my interview with Carole Draper, I explained that a case conference was held on 10 December. D seemed to have calmed down after a disturbed period and had not demonstrated any suicidal ideation or self-harm intentions. It seems that we therefore took the decision to reduce his level of observations from constant to 15 minute documented observations at this case conference.

64. I also state in my transcript that I believe that chlorpromazine was prescribed to D to help him sleep. Chlorpromazine was often prescribed in those days by many visiting psychiatrist as a major tranquiliser and as a sedative. This is why I suspect that D might have been seen by one of the visiting general psychiatrists. Without D's medical records I cannot confirm whether or not this was actually prescribed to D, the reasons why it was prescribed and by whom. Discussion of D and his therapeutics without access to his treatment card, nursing care plans and his inmate medical record can lead to misleading conclusions.

19 December

65. The Gate Book for the 19 December is now produced and shown to me as **exhibit MY3**. It reveals that on that date I came into the prison at 11.00. The log says that I left the prison at 18.25. This is not likely to be accurate, as the gate staff would stop work at 18h30. Anyone who had not been seen to leave by 18.25 was logged as having left at that time. It was my usual practice to work until 19.00 or 20.00 as I found that it was only in the evenings that I had time to do my paperwork. I also offered additional clinical cover during those hours as the reception duties could be very heavy.

66. The Gate Book entry from 19 December shows that Dr Ranawerra was on duty in the Health Care Centre on 19 December and that Tony Madden was also on duty. Dr Akinkumni came in from 10.15 until 11.45. I also note that Dr Duffield, another psychiatrist was also in the prison throughout the morning until 14.20. There could have been any number of reasons why Dr Akinkumni only stayed for 90 minutes on that day.

67. Without the IMR and nursing care plans it is not possible to say what steps D's doctor and nurses took to follow up on the referrals made to the psychiatrist. Dr Ranawerra was D's doctor and she was well known for her meticulous record keeping. She wrote any action that she took into the patient's IMR.

68. It is very unusual that an urgent referral was made but that D was not seen. This may have been due to the teething problems with the new system of referrals or staff/system changes. However, it is difficult for me to speculate about this as under the new system, the decision making process regarding referrals had been

taken out of the doctors' hands. I wonder if D was actually seen by any of the visiting general psychiatrists, particularly after the emergency tranquilization.

27 December 2001

69. I was not on duty in the Health Care Centre on 27 December 2001. I have no recollection of a noose and a broken razor being found in D's cell. It is clear that D was feeling frustrated on 27 December as he smashed up his cell. It seems sensible that Officer Leane offered to give D a phone call at public expense to try and settle him. Although Standing Order 13 states that a doctor should be present if bad news is to be conveyed to a prisoner, I must say that this is a very antiquated document. It had been heavily amended and was only maintained in force until such time as a new nationwide policy could be formulated. It should be remembered that HMP Pentonville was ahead of its time in terms of the management of self-harmers and that staff were well accustomed to dealing with disturbed prisoners. They knew that there needed to be a process in place to support patients when they received bad news. However, if a patient who receives bad news does not want to discuss their difficulties straight away, you have to respect that and the best you can do in that case is to ensure that the patient is regularly observed.

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

70. I regret to say that I do not think that you will ever be able to completely eliminate suicides in prison. I believe that a decent detoxification regime is key to

minimising acts of self-harm because, by providing an effective drug based rehabilitation, prisoners will not self-harm as a means of procuring drugs.

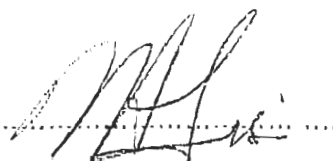
71. I strongly favour the use of wards as a means of suicide prevention. However, that said, sometimes doing everything that you can to prevent suicides in the prison environment can lead to an increase in the levels of self-harm. We noted an increase in the number of self-harm incidents when the wards were closed because some prisoners missed the interaction that they had known with other patients in the ward environment.

72. Staffing is also very important. I note that there are now over 60 members of staff working in the healthcare and detoxification units at HMP Pentonville and there are 6 people doing the roles which were formerly within the remit of the SMO and Head of Healthcare.

73. As far as D is concerned, it is impossible to say whether he would have behaved as he did, even if he had seen the psychiatrist in December 2001 as it is not certain that his condition would have improved on having seen a psychiatrist. That said, I find it highly unlikely that he was not seen by anyone during that period, for the reasons stated above. I strongly believe that the clinical and healthcare staff that worked with me did their best for D as for all of our patients and that the Emergency Medical Response Team should be praised for having revived and resuscitated D.

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

Signed.....



Position..... GP.

Date..... 12/11/2007.