

LIST OF ISSUES

1. The Investigation will seek to establish the circumstances and events leading up to and immediately following the near suicide of Mr D on 27 December 2001, to the extent that doubt remains about these matters in the light of the report prepared by Carole Draper.

2. The Investigation will consider:
 - a. The clinical care provided to Mr D and its adequacy;
 - b. The steps taken in relation to Mr D in consequence of the clinical and other assessments made, including in particular:
 - i. case conferences;
 - ii. the system of referral to a psychiatrist and psychologist;
 - iii. the operation of that system in relation to Mr D and the reasons for him not being seen by a psychiatrist;
 - iv. the availability of specialist psychiatric and psychological care;
 - v. whether there was any delay in Mr D being seen by the psychologist and, if so, the consequence, if any;
 - vi. the consequence, if any, of Mr D not being seen by a psychiatrist.
 - c. To the extent that it is not possible to assess the adequacy of the clinical care provided, to consider why this is so.

- d. The extent to which care provided to Mr D compares to that which might reasonably have been expected in the prison and to consider any wider policy issues arising.
 - e. any relevant outside factors.
3. The investigation will consider the systems in place at HMP Pentonville for the identification, assessment and care of those at risk of suicide and/or self-harm and how those systems operated in relation to Mr D. Including consideration of:
- a. The nature and extent of health care facilities available at HMP Pentonville in so far as is this relevant to the identification, assessment and care of those at risk of suicide and/or self-harm including the quality of nursing care and the use of agency staff;
 - b. The suitability of the environment within the Healthcare Centre for the care of inmates at risk of suicide and/or self-harm;
 - c. The system of record keeping in relation to those at risk of self-harm or suicide, the reliability of that system and the availability of records during consultations;
 - d. The operation of the F2052SH including:
 - i. the system of “hand-over” to HMP Pentonville when the form has been raised by another agency; and
 - ii. whether it was appropriate for the documentation to be removed during case conferences;

- e. The nature and adequacy of F2052SH case conferences, including consideration of whether it would be appropriate for them to be multi-disciplinary and whether the prisoner should be present;
 - e. The system and adequacy of watches and record keeping in relation to watches;
 - f. The nature and adequacy of training of staff in relation to suicide and self-harm procedures, including in particular refresher training;
 - g. Whether it was clear in December 2001 who had authority to determine where a prisoner at risk of self-harm or suicide should be accommodated and the nature of the watch to which they should be subject and, if not clear then whether the position has changed.
 - h. The nature and adequacy of the system for responding to discovery of incidents of self-harm and suicide including the role and training of Hotel 9 and the location and availability of implements for cutting ligatures;
 - i. Any national and local guidance and policies;
 - j. Their adequacy;
 - k. Their application at HMP Pentonville, then and now;
4. To consider the relevance, and where relevant, outcome of any internal investigations in relation to self-harm, suicides and near suicides. Including, in particular, consideration of:
- a. The extent to which relevant recommendations made prior to December 2001 had or had not been implemented;

- b. The extent to which any implementation or non-implementation of such recommendations might have a bearing on Mr D;
 - c. To establish and consider the system for implementing recommendations of such investigations;
 - d. To establish the extent to which the recommendations of the Draper Investigation and any of relevant investigations or inquiries since December 2001 have or have not been implemented and, in so far as they have not been implemented to consider why.
5. The Investigation will consider whether any change in operational methods, policy, practice or management arrangements would help prevent suicide and self-harm in Pentonville and other prisons.