THE 'D' INVESTIGATION

COUNSEL TO THE INVESTIGATION'S OPENING STATEMENT

INTRODUCTION

1. Mr D was born on 25 December 1979. On 30 November 2001 he appeared before Thames Magistrates' Court charged with, amongst other things, attempted theft and possession of an offensive weapon. He had spent the previous night in police custody. He arrived at court with a Prisoner Escort Record ("PER") marked to indicate that he was considered to be at risk of self-harm or suicide. The form indicated that he had existing injuries. At court the Securicor staff opened a Self-Harm At Risk Form, often referred to as a "2052SH". He was placed on a 15 minute watch. The court remanded him into custody. Whilst at court he inflicted further injuries upon himself. He was taken to HMP Pentonville ("Pentonville" or "the prison") via hospital.

2. On arrival at the prison Mr D was assessed in Reception and admitted to the Healthcare Centre ("HCC"). He remained in the HCC over the following 4 weeks. During that time, as I shall set out in detail in due course, he received some medical attention. He inflicted or threatened to inflict further injuries upon himself. He threatened to kill himself. On one occasion he was found to be in possession of a razor and had created a noose from his bedding. For much or all of the time he was in the HCC he was subject to regular observation. Nevertheless on 27 December, a few days after his 22nd birthday, Mr D was found hanging from the light fitting of his cell. As soon as he was discovered immediate steps were taken in an effort to save him. These were successful, however Mr D

suffered injury to his brain and is left seriously impaired. He now suffers from a mental impairment within the meaning of the Mental Health Act 1983.

3. You have been asked by the Home Secretary to conduct an investigation in the circumstances surrounding the near death of Mr D and to report to him. The Terms of Reference are as follows:

> "Having regard to the Court of Appeal judgment of 28 February 2006, to conduct an Article 2 compliant investigation into and report to the Secretary of State for the Home Department on the circumstances surrounding the near suicide of a young man (Mr D) at HMP Pentonville on 27 December 2001. In particular:
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> - To establish the circumstances and events, especially as regard management of Mr D by the Prison Service, including considering any information about how prisoners at risk of self-harm were cared for at Pentonville, and to consider relevant outside factors.
> - To examine whether any change in operational methods, policy, practice or management arrangements would help prevent suicide and self-harm in Pentonville and other prisons.
> - Where possible, to examine relevant health issues and to assess Mr D's clinical care and consider any wider policy issues arising.
> - To examine the extent to which the recommendations of the earlier internal Prison Service investigation have been implemented.
> - To consider the implications for future investigations into near suicides"

4. The investigation is required to comply with Article 2 of the European Convention on Human Rights ("the Convention"). In the context of a death in custody the House of Lords has explained that the purpose of such an investigation is:

> "to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others"[1]

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[1] *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 632 paragraph 32

The same principles apply to this investigation.

5. In related proceedings in the High Court the court made an order that:

"Nothing shall be published that will identify D, a patient, pursuant to [the Civil Procedure Rules] Part 21".

Although that Order does not directly apply to these proceedings it is the intention of the investigation that Mr D's identity should remain protected and accordingly he will be referred to simply as Mr D.

6. Today marks the start of the public phase of the investigation and follows on from the evidence gathering phase. My role in these hearings is not to argue for any particular conclusion or result, but rather to assist the investigation in its task to ensure that so far as possible the full facts are brought to light and relevant matters are examined so as to ensure that the investigation is able to fulfils its obligations in accordance with the Terms of Reference.

7. There are two interested parties to this investigation represented at these hearings: Mr D who is represented by Ms Kristina Stern of counsel and the Prison Service which is represented by Mr Eadie of counsel.

PROCEDURE AT HEARINGS

8. All of those who have provided evidence to the investigation have done so in the form of written statements and/or in the course of interviews. The investigation is very grateful to all those who have cooperated with and assisted in this process. In consultation with the interested parties the investigation has identified a number of witnesses from whom it proposes to adduce evidence. That will be done either in the form of oral evidence or written statements and/or interviews provided by people it has not been thought necessary to ask to attend the hearings. Nevertheless that material will form part of the evidence before the Investigation and I shall introduce it as we proceed.

9. The interested parties have been consulted about the procedure to be adopted at the hearings which is set out in the Investigation's Procedural document dated 29 September 2006.

10. The public hearings will be dealt with in two parts. Regrettably, it has not proved possible for all the relevant evidence and witnesses to be available this week. In the circumstances the Investigation will deal in the course of this week with the non-medical evidence, save for evidence from a clinical psychologist. A further hearing will be arranged in early September at which the medical evidence will be considered. This is not ideal. However, the alternative of postponing the hearings in their entirety was far less satisfactory.

11. The evidence before the Investigation will be made public. That will be achieved both by the hearings themselves being in public but also by the posting of the evidence on the Investigation's web site. At the conclusion of each day's evidence it is proposed that a transcript of the evidence heard, together with copies of the witness statements, interviews and documents referred to will be placed on the web site.

SCOPE OF INVESTIGATION

12. The primary focus of the Investigation relates to Mr D. However, as the Terms of Reference make clear, it will be necessary for the Investigation to consider the systems and procedures that were in place at the Prison to identify and care for prisoners such as Mr D who were or might be at risk of self-harm.

13. Mr D attempted to take his life over 5 years ago. In the intervening years things have moved on. It will not form part of this Investigation's function to examine in detail what has happened in the intervening years. Rather, the Investigation is tasked with making recommendations for preventing suicides and self harm in prisons in the future. Accordingly, it is proposed to examine operational methods,

policy, practice and management arrangements that were in place in December 2001 and that are in place today. In that way, it is hoped and intended that such recommendations as may me made will not dwell on the past but be constructive for the future.

THE CONTEXT

14. Incidents of prisoners, especially young men, harming themselves or attempting to take their own lives are not uncommon. In June of 2006 HM Chief Inspector of Prisons reported that in the course of 2005 at Pentonville alone there had been three near suicides and that the self-harm incidents reported in the previous six months included four where prisoners found hanging had been cut free by staff.

15. More generally in speeches delivered in 2004 the House of Lords observed in *R (Middleton) v West Somerset Coroner*[2]:

> "The statistics … make grim reading. While the suicide rate among the population as a whole is falling, the rate among prisoners is rising. In the 14 years 1990-2003 there were 947 self-inflicted deaths in prison, 177 of which were of detainees aged 21 or under. Currently, almost two people kill themselves in prison each week. Over a third have been convicted of no offence. One in five is a woman (a proportion far in excess of the female prison population). One in five deaths occurs in a prison hospital or segregation unit. 40% of self-inflicted deaths occur within the first month of custody. It must of course be remembered that many of those in prison are vulnerable, inadequate or mentally disturbed; many have drug problems; and imprisonment is inevitably, for some, a very traumatic experience. These statistics, grim though they are, do not of themselves point towards any dereliction of duty on the part of the authorities (which have given much attention to the problem) or any individual official. But they do highlight the need for an investigative regime which will not only expose any past violation of the state's substantive obligations already referred to but also, within the bounds of what is practicable, promote measures to prevent or minimise the risk of future violations. The death of any person involuntarily in the custody of the state, otherwise than from natural causes, can never be other than a ground for concern".

16. Prison Service statistics show that in 2003 there were 94 suicides and 16,221 recorded incidents of self-harm (including 204 resuscitations) across the Prison

[2] [2004] 2 AC 182

Service and that the corresponding figures for the nine months from January to September 2004 were 95, 11822 and 102. Between 1996 and 2007 there were 14 self-inflicted deaths at Pentonville. In the more recent past, the number of self-inflicted deaths in prisons has declined, but this year the trend is upward.

17. It is against that background that this Investigation embarks upon its task.

HMP PENTONVILLE

18. The prison opened in 1842. It was and has remained ever since a local prison. Today it serves the courts of north east London. It has an operational capacity of 1,177. It has to deal with substantial number of prisoner movements. In 2006 the average number of new prisoners coming into the prison every month was 672.

19. At and about the time of Mr D's imprisonment the HCC was housed in the most unsatisfactory accommodation. This had been widely recognised. In January 2000 HM Chief Inspector reported:

> "… the greatest deficiency in Pentonville remains the lack of a proper Healthcare centre. Five years ago the old Healthcare Centre was evacuated in order for it to be demolished and rebuilt, after which the unsatisfactory accommodation, into which it moved temporarily, would be redeveloped. However, the Government then imposed drastic cuts in capital funding on the Prison Service, with the result that the plan was suspended, and five years on, the Healthcare Centre is still temporarily housed in unsatisfactory accommodation. To make matters worse the numbers of mental disordered prisoners in the Healthcare Centre make it one of the largest medium secure units (MSU) in the country, with a staffing ratio of one staff to 10 prisoners as opposed to 6 staff to 1 patient in an MSU. This gross understaffing, coupled with the antediluvian conditions in which patients are held is compounded by the fact that, along with every other prison in the system, no Healthcare needs assessment, as required by the Prisons Board to have been carried out by July 1997, had been completed. Nor had any action plan following our July 1998 inspection.
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> … I am not surprised that morale was low amongst staff who had to work in such conditions. The one redeeming factor is the speed with which the Senior Medical Officer is able to arrange for the transfer of seriously mentally disordered offenders in the NHS … I will not mince words. Healthcare arrangements at

Pentonville are a disgrace which, which should never have been allowed to happen".

20. The accommodation problem has since been resolved. At a cost of some £7m the new HCC has since opened. The extent to which this has, of itself, affected the care for those at risk of self-harm and suicide is a matter to be addressed in the evidence.

MR D AND EVENTS AT PENTONVILLE

21. As will become apparent, one of the features of this case is the absence of contemporaneous documentation virtually all of which has been lost by the Prison Service. Following Mr D's attempt upon his life the Prison Service tasked Ms Draper, then a Senior Investigating Officer at the London Area Office of the Prison Service to undertake an investigation. At that time much of the contemporaneous material since lost was available. However, even at that early stage some material was absent: in particular the 15 minute observation log for the very day Mr D attempted to take his life. However, from the material that is available including in particular Ms Draper's report it is possible to identify the following sequence of events in relation to D[3].

22. On 19 June 2000 whilst at Newham Magistrates Court Mr D self-harmed by inflicting cuts to right wrist. On 10 August 2000 in a letter to his GP it was reported that:

> "He has a diagnosis of personality disorder of the emotionally unstable type, associated with poor impulse control. He has significant problems with alcohol and drugs (cannabis, cocaine and crack). He had been treated with anti-depressants whilst at Feltham YOI and has a tendency to self-harm"

[3] I am grateful to Ms Chahal of Bindman and Partners, solicitor for Mr D, for her draft chronology which has been of much assistance

23. As I have already stated, on 29 November 2001 he was held overnight in police custody arriving at court the next day with a PER indicating existing injuries and marked for self-harm/suicide. On arrival at 09.45 a F2052SH was opened by Securicor who placed him on a 15 minute. At 12.45, after his court appearance, he was found to have further injuries which required hospital treatment. He was discharged from hospital at 15:50 and thereafter taken under constant observation to Pentonville.

24. He arrived at Pentonville at 16.25. He was assessed in reception and was admitted to the Health Care Centre on an open F2052SH and was also given an alcohol detoxification prescription. It is not presently clear whether he remained on an open F2052SH continually until 27 December 2001. He was found to have deliberately self-harmed on both arms and stated that he felt very depressed due to the breaking up of his relationship with his girlfriend who was pregnant by his friend and that he felt hopeless about the future. Mr D was admitted to the shared ward facility, Ward 3, and referred for an urgent assessment by medical staff. Dr Ranaweera saw him at 17.30 and referred him to the visiting psychiatrist. That referral was itself marked "Urgent" and double underlined.

25. At 14.30 on 1 December Mr D became threatening and disruptive. It was apparently reported by Ward staff that he attempted to throw a chair through the window of ward office. He was moved to a cell known as AS3. He was spoken to and "seemed miserable and was moaning about his move". The entry went on to note that "positive support and counselling provided to him" and recorded the following under the heading Action:

> "(1) Refer to duty ?
> (2) 15 min … watch …
> (3) Assess mental state ASAP
> (4) Review further care and management"

As a result of his conduct he was placed on a charge of contravening the Prison Rules.

26. Later that day at about 18.10 Mr D threatened to self-harm with a pencil. But, he remained quiet the rest of the night and following day.

27. At 09.40 on 3 December Mr D seen to be re-opening a cut on his left arm made previously by stabbing himself with a knife. He said that he would kill himself by Friday next week before he has a court appearance. Also says he will harm staff and ex-girlfriend and spoke of getting a gun to shoot others with or using a knife. He was referred to and seen by Dr Ranaweera. A full history was taken. Mr D admitted that he had a history of self harm and had previously been in a Young Offender Institution but this was his first time in an adult prison. He admitted to a heavy alcohol habit. He said that he had lived with his girlfriend for 2½ years and had a child by her. He was anxious and seemed to have multiple superficial lacerations to both arms, but was not considered actively suicidal nor clinically depressed. An urgent referral was made to the visiting clinical psychologist for counselling and a visiting psychiatrist for a mental assessment as well as the Chaplain, Samaritans and Listeners.

28. Later that day at 19.45 he was found to have blocked the observation holes of his cell and to have jammed the cell door (R1-09). A prison officer forced the door open. Mr D was found to have self-harmed using a small piece of porcelain. He had lacerations to both forearms/wrists plus small cut to neck. An entry in the Information Book refers to Mr D holding "item to his throat".

29. At 21.15 he was seen by a doctor who prescribed some medication and referred him urgently to the visiting psychiatrist.

30. On 4 December at 0830 PO Richards moved Mr D from Ward 3 to AS3 whereupon Mr D kicked the toilet unit which fell apart. He was placed on report

and moved again to R1 – 24. It was noted that he "Seems to have calmed down but still claims he will harm himself given the opportunity". PO Richards also recorded that his behaviour was deteriorating, that he was becoming paranoid, hearing voices that were telling him they were going for his daughter.

31. He was seen by Dr Yisa the Senior Medical Officer who sedated him and placed him on a documented 15 minute watch. Dr Yisa requested an urgent referral to a psychologist and psychiatrist.

32. At some stage that morning Mr D threatened cleaners and staff with violence and it was noted that 3 staff should be present when unlocking his cell. At 11:00 he was due to attend an Adjudication but was unfit to plead by reason of his medication. The Adjudication record was completed in part by a medical officer who wrote: "Note fir for cellular confinement. Awaiting psychiatric assessment".

33. During the morning of 4 December a Case Conference was held. This was attended by medical and nursing staff. He was placed on one to one watch for at least next 24 hours. A further urgent referral was made for assessment by clinical psychologist and psychiatrist.

34. At 12.00 Mr D ripped off dressings from both arms and told staff he did not want to live. He was assessed by a doctor who maintained him on a one to one watch and noted that he was awaiting assessment by specialists. Thereafter he appears to have slept.

35. By a letter dated 4 December the clinical psychologist, Dr Halsey, acknowledged receipt of Dr Ranaweera's referral and says that Mr D will be seen within a month.

36. On either the 4 or 5 December Dr Yisa administered some medication to Mr D and instructed "do not give any further meds today or tomorrow".

37. On 5 December Mr D was again due to attend an Adjudication but was unfit to plead and it was noted that he “had to be injected and is too drowsy”.

38. Mr D was listed to be seen on 5 December by Dr Akinkunmi, a psychiatrist, but was not seen.

39. On 6 December Mr D was due a legal visit but this was cancelled because he was not feeling well. At this stage he was due to be observed once an hour. A Case Conference was held during that day. The view was apparently that Mr D was more settled. Dr Yisa had seen him because he had been banging his head.

40. At 18.15 he was seen to rip up bed sheet which he attempted to conceal but which he handed over when asked.

41. On 7 December he attended Thames Magistrates Court where he further self-harmed by cutting both arms with a small piece of tile board. He was seen by the Force Medical Examiner. Although he probably remained on an open 2053SH the documents are not consistent. He returned to Pentonville very tearful and complaining of lock-jaw. He was to be reviewed by a doctor. It is also recorded that he told staff they would not stop him self-harming if he could not see his daughter.

42. On 8 December he was seen by a doctor and kept on a one to one watch.

43. On 10 December he was due to attend an Adjudication but this was adjourned to obtain a medical report. In the course of that day a Case Conference was held at which he was regarded as more settled, the 2052SH was kept open but the level of watch reduced to 15 minute documented.

44. On 11 December a further Case Conference was held and the level of watch reduced to 15 minute supported. He was also referred to the education department.

45. On 13 December there was a further Case Conference by which time Mr D was considered to have settled well, not to be clinically depressed or suicidal. It was proposed to relocate him to a normal shared cell, the 2052SH to remain open and for him to be assessed by the visiting psychiatrist and psychologist. A support plan and discharge report was drawn up in 2052SH.

46. However, on the same day Mr D returned from exercise asking for something to help him sleep and demanding to see a doctor. He was told that none was available because they were in a clinical meeting. He become abusive and threw furniture. An entry in the log was made. Under the heading Action, a health care officer wrote: "What action is being taken?".

47. At 14.00 Mr D again self-harmed by attempting to hang himself using his bedding. He was discovered by a patrolling nurse who found him "hanging on his window with a piece of bed sheet". He was cut down. No loss of consciousness was observed. He was seen by Dr Yisa who placed him on one to one watch in a semi furnished cell and referred him to Listeners, Samaritans and Probation. There is a suggestion in one document that no 2052SH was open at this time.

48. On 14 December he attended Thames Magistrates' Court and was remanded to appear at Southwark Crown Court on 20 Dec. He returned to Pentonville to cell AS3 (semi-furnished) on a 15 minute documented watch until he was seen by a doctor.

49. On 15 December he was relocated to a single cell (R1-21). He remained settled and interacted with staff and other prisoners.

50. At about 15:00 on 16 December he had a period of head banging telling staff he was missing his daughter. However, he calmed and went on association.

51. On 18 December Mr D had a social visit. A Case Conference was held at which the view was that Mr D was not mentally ill or clinically depressed, he was anxious but not suicidal. A decision was made to keep him in the HCC for mental observation on a 15 minute supportive watch and to continue the F2052SH.

52. On the same day he was seen by Dr Halsey, a clinical psychologist. Dr Halsey found the examination largely unproductive. But he noted that:

> "He repeatedly returned to the theme of wanting to die and his attentions (sic) to kill himself".

He said that he was hearing voices telling him to kill himself. Dr Halsey recorded this in a letter to Dr Ranaweera dated 25 January 2002. Dr Halsey formed the opinion that Mr D's presentation indicated a need for psychiatric evaluation. Dr Halsey listed him to be seen the following day, but if not seen for any reason he should be included on the list for the visiting psychiatrist at the earliest opportunity.

53. On 19 December at 12.00 Mr D was seen to be throwing things in his cell but would not say why. He was listed to be seen by Dr Akinkunmi, a psychiatrist, but not seen.

54. On 20 December Mr D attended Court. Over the following days entries in F2052SH apparently suggested he was in a congenial mood and interacted well with staff and other prisoners.

55. On Christmas Day Mr D apparently called out to another prisoner that he was going to die that night. He apparently told staff he was not alright but would not say why.

56. During the morning of 27 December a routine cell search revealed a broken razor blade or blades and a noose in Mr D's cell. He said that the former was for cutting matches and the noose was intended as a joke. The discovery was reported to a senior member of staff. The nurse undertaking observation of Mr D says that he kept blocking the observation holes and she had to ask him not to do so.

57. At 15.00 HCSO Hayward recorded that Mr D became abusive and aggressive. He smashed his locker and said he "couldn't stand being banged up any longer". Furniture was removed from his cell as a precaution. PO Leane agreed with HCSO Hayward (who was in charge of inpatients for the day) that Mr D could be given a phone call in hope that would calm him.

58. During the telephone call, Mr D learnt that his daughter had been taken into social services care, which caused him great distress. He was very tearful and obviously distressed after the call, although he was placed in his cell. An entry was made in the F2052SH and healthcare observation book that staff should be extra vigilant in relation to Mr D. Mr Hayward made an entry which read:

"apparently his child has been taken into care by social services – already on 15 min watch – staff need to be vigilant".

59. At about 15.35 Nurse Chikuku observed Mr D. She next retuned to observe him at about 15.45. In the course of an interview she explained what happened next as follows:

"Then when I came back again after 10 minutes, there was a newspaper on the flap and I just take the newspaper off then I saw Mr D hanging himself. I called for help, I called for scissors and [pressed] the alarm – that's when the crew came in".

The alarm was raised and Officers Hayward, Murray, Leane and Richards attend the cell (R1-18). They supported his weight whilst awaiting the anti-ligature

scissors which were not readily available. The health care response team arrived and took over the incident. Mr D was fitted with an airway and was given adrenaline by the prison doctor, Dr Khan. He was also fitted with a spinal collar in case of spinal injury. An ambulance was called at 15.51 and the ambulance crew were present by 16.00. Mr D was taken by Air Ambulance to the Royal Free Hospital.

60. Thus, the material now available reveals that between 30 November and 27 December 2001 Mr D self-harmed, threatened to self-harm or was found in possession of items with which he could self-harm on at least 12 occasions. The representatives of Mr D suggest that the correct figure is not less than 18. He was referred to the visiting psychiatrist on at least 6 occasions. Some of the referrals were said to be urgent. Yet, despite the visiting psychiatrist attending the prison and despite being twice listed to him he was not seen. He was to be referred to the Listeners, the Samaritans and Probation. There is no record of those referrals actually being made and on any view it is clear he was not seen by any of them. There is no evidence that any of the referrals were monitored or steps take to ensure they were actioned. The attempt to take his own life which so nearly succeeded on 27 December 2001 followed receipt of distressing news about his daughter. Concern for his daughter had previously been a trigger for threats to self-harm. Notwithstanding that Mr D had been recognised as being at risk of self harm or suicide for much if not all of his short time at Pentonville such steps as were taken to care for him proved ineffective. The issue at the centre of this investigation will be to consider why this was so.

THE DRAPER AND OTHER INVESTIGATIONS

61. Ms Draper was appointed by the Prison Service to conduct an investigation. She did so and reported on 22 July 2002. She conducted interviews with a number of people and had access to documents which have since been lost. However, as already noted, even at that early stage the 15 minute observation log in relation to Mr D for 27 December was not available. She concluded that:

(a) The system of referrals to the psychiatrist was not effective. By the time she reported a new system had been introduced but she was not satisfied that was effective either;

(b) Case Conferences were not satisfactory. She noted that this was a matter raised in several previous reports;

(c) There was a lack of training and advice for agency nurses who were specifically engaged to observe prisoners subject to special watches;

(d) The location of the anti-ligature scissors meant that they were not immediately available;

(e) There was uncertainty as to who had authority to place a prisoner on watch or vary the nature of that watch;

(f) Training in relation to the F2051SH form was inadequate, especially in respect of the agency nurses;

(g) Documentation in the HCC was not to the required standard;

(h) Considerable effort had gone into caring for Mr D but the incidents on 25 December and the morning of 27 December when he either threatened to kill himself or was found with items with which he could self-harm, although recorded in the 2052SH resulted in no action being taken. She concluded that both incidents should have been followed up by senior staff and further assessments made as to whether Mr D posed an increased threat of self-harm;

(i) The nurse responsible for observing Mr D on 27 December was not told of the outcome of the phone call and this information should have been passed to her.

62. Ms Draper made a series of recommendations. The investigation will wish to consider the extent to which they have been implemented. However, she noted that she had not included "any review of self-harm issues as these have been covered in other reports and are being considered by Mr Sheikh in his more recent

investigations". So far as the Investigation is aware Ms Draper conducted the following additional investigations into deaths at the prison:

(i) Report into the death of Mr M who died on 10 October 2001 of drug poisoning. The drugs were self-administered;
(ii) Report into the death of Mr AD who attempted to hang himself on 3 November 2001 and subsequently died;
(iii) Report into the death of Mr C who died on 28 December 2001. This was not a case of self-harm;
(iv) Report into the death of Mr N who died on 8 July 2002.

63. Further, Mr Sheikh, also a Senior Investigating Officer, conducted an investigation into the death of Mr W who hanged himself in his cell in the HCC on 22 June 2002. In the light of the significance Ms Draper attached to the recommendations set out in Mr Shiekh's report this investigation will wish to consider the extent to which they have been implemented. More generally it is also apparent that some of these reports identify common themes in relation to, for example, case conferences, standard of record keeping in the HCC and the location of anti-ligature scissors. The investigation will wish to consider the significance, if any, of these.

SYSTEMIC ISSUES

64. It might be thought that one of the most striking features of Mr D's short time at Pentonville is that he was recognised as being at risk of self-harm, and was for most or all of the time subject to the 2052SH system of monitoring, yet was still able so very nearly to succeed in taking his own life. Does that suggest that there were systemic failings in his care and management?

65. On one view it might be said that if someone is determined to take their own life there is nothing that can be done to stop them. That however was certainly not the view of the Prison Service which had long had in place systems to try and prevent

people harming or taking their own lives. Instruction to Governors 1/1994 had as its stated aim:

> "The Prison Service has a duty to care for all prisoners, We aim particularly to identify, and provide special care for prisoners in distress and despair and so reduce the risk of suicide and self-harm"

It went on to state:

> "Special care: Identifying and supporting prisoners in crisis and treating them with dignity
>
> There will always be some people, in prison as in the community, who feel like harming or killing themselves. We aim to care for prisoners in crisis by:
>
> - Doing everything we can to identify the times of suicidal crisis
> - Treating the suicidal with compassion and preserving their individual dignity
> - Allowing opportunities to talk about suicidal feelings and encouraging them to make positive choices
> - Providing supportive human contact and supervision
> - Protecting the suicidal as far as possible from harming themselves"

Under this Instruction Governors had overall responsibility for implementing the suicide awareness policy. It stated that the Prison Service aimed to provide staff with training and support

66. A further Instruction was issued in November 1994 (IG 79/1994). It stated:

> "The care of prisoners who are at risk of suicide and self harm is one of the Prison Service's most vital tasks … This further Instruction arises from the need to ensure that all that is possible is being done to reduce the risk of suicide …".

The instruction contained:

(a) Instruction on the use of 15 minute watches

(b) A reminder of the priority to be attached to staff training

(c) An overview of action being taken

In relation to staff training Governors were to ensure that their establishment had a sufficient number of trainers and that all staff were trained in the training module "Caring for the Suicidal in Custody".

67. The F2052SH Self Harm at Risk form was intended to introduce a structured plan for supporting and caring for those identified as being at risk of self harm. It identified in particular the need to listen to the prisoner and identify his or her concerns and issues with which they were not coping, the need for a support plan, which might include a key worker and the need to review the prisoner's needs. The form was only to be closed when the prisoner appeared to be coping satisfactorily. The decision had to be taken at a case conference after discussion with the prisoner.

68. In 1997 the Prison Service produced a guide to the policy and procedures for entitled *Caring for the Suicidal in Custody*. In May 1999 HM Chief Inspector of Prisons published a thematic review entitled *Suicide is Everyone's Concern*. The Chief Inspector noted that:

> "3.8 It is known that most prisoners who injure themselves, many repeatedly, do not go on to kill themselves. However, a significant proportion of those who commit suicide do have a history of self-mutilation. It is also known that in the community those who harm themselves are 100 times more likely to kill themselves than the general population and that 10 per cent of this group do eventually carry this out. Thus although self-mutilation may become established as a coping device or a way of dealing with pain and staying alive it may develop into a method of achieving complete release in death.
>
> 3.9 Therefore, aside from the importance of responding to self-injuring behaviour on humanitarian grounds as it signals acute distress in a fellow human being, it is also important that it is responded to because of the possibility that it may develop into fatal self injury in the future …"

69. The Chief Inspector reviewed the effectiveness of the practices then in place. He concluded that although the work of the Suicide Awareness Support Unit had

been impressive, the policy then in place *Caring for the Suicidal in Custody* failed to give sufficient attention to the particular needs of women, young prisoners and those in local prisons. He noted among others things that communication between staff about prisoners who were suicidal was generally poor and that there was too much emphasis on filling in form F2052SH rather than ensuring the proper care for the suicidal. His report made a series of recommendations, including a new strategy for preventing suicide in local prisons. In summary that was as follows:

- There must be a total commitment to reducing suicide in local prisons from Minsters and the Prisons Board
- Suicide prevention should be a top priority for all levels of management
- There should be much better training for all local prison staff in recognising and responding to vulnerable prisoners
- There should be more effective initial risk assessment in reception
- All new receptions should be held for 48 hours under close observation in a dedicated induction area
- Specialist trained staff should interview and support at risk prisoners
- All at risk prisoners should have a care plan
- There should be more use of prisoners to assist staff to prevent suicide
- There should be co-operation between specialist trained staff and health care staff.

70. At Pentonville the Suicide Prevention Team produced a Policy Document in 2001. The aim of the policy was:

"To prevent prisoners from committing suicide or committing acts of self harm against themselves"

It went on to state:

"Every member of staff must read this document. Every person working in or visiting the prison is expected to follow the policy and procedures outlined in it.

Through compliance with these procedures and the maintenance of high levels of care and support for vulnerable prisoners, we assure our moral and statutory obligations"

The policy introduced a formalised system of case conferences to ensure that prisoners were being actively managed while on F2052SH. That required weekly multi-disciplinary case reviews including the prisoner. There was to be a Support Plan. Personal Officers (or Key Caseworkers) were to ensure the Support Plan was followed. The policy set out a Suicide Prevention Action Plan which included the provision of staff training in suicide.

71. As already noted those at risk of self-harm or suicide might also have access to the Samaritans, Listeners (prisoners who have been trained by the Samaritans) and the Chaplain.

72. More generally it was the policy of the Prison Service that the standard of healthcare aimed for was:

"To provide prisoners with access to the same range and quality of services as the general public received from the National Health Service"

73. The Investigation will wish to consider the operation and effectiveness of these policies in relation to Mr D and more generally at Pentonville.

THE PRESENT DAY

74. As already indicated things have moved on since December 2001. The F2052SH is no longer operated. Prison Service Order 2700 dated 1 June 2005 introduced the Assessment, Care in Custody & Teamwork ("ACCT") system in its place. The stated purpose is to build on existing good practice. It is a care-planning system whereby staff from all disciplines work together to provide individual care to prisoner with long-term needs, such as those with a pattern of repetitive self-harm. It is intended to focus on people not processes and individual care. The investigation will wish to consider whether any of the lessons to be learnt from

the circumstances of Mr D's case may nevertheless be relevant to the operation of this new scheme.

75. There are some promising signs. The Pentonville Independent Monitoring Board reported in 2006 that in relation to suicide prevention:

> "There are reasons to believe that the prison's systems for preventing self-harm are improving. For example, the monthly Safer Custody Team meeting has not suffered the frequent changes in chairmanship which we criticised last year. Those meetings have been better attended than before, with regular representation from most parts of the prison, and they seem much better focussed than hitherto"

It noted the "major development" of the introduction of the ACCT and that it had entailed a major programme of staff training which:

> "has gone a long way to meeting out previous criticism that training in suicide prevention procedures had been neglected"

76. These comments will, however, have to be considered in the context of the most recent report of the HM Chief Inspector following an inspection in June 2006 which identified a number of shortcomings in relation to the implementation of prevention of self-harm and suicide policies and primary mental health care.

SUMMARY OF ISSUES TO BE CONSIDERED

77. The purpose of this opening is to put the evidence which is to follow into context. It is not intended to prejudge that evidence or seek at this stage to invite any particular conclusion. The Investigation has, in consultation with the interested parties identified the following issues for its consideration:

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 unavailable 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;
    f. The system and adequacy of watches and record keeping in relation to watches;
    g. The nature and adequacy of training of staff in relation to suicide and self-harm procedures, including in particular refresher training;
    h. 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.

i. 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;
j. Any national and local guidance and policies;
k. Their adequacy;
l. 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 other 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.

6. To consider the implications for future investigations into near suicides.

That is the task upon which we now embark.

KEITH MORTON

5 July 2007

1, Temple Gardens

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