THE INVESTIGATION INTO THE SUICIDE ATTEMPT BY D AT HMP PENTONVILLE ON 27 DECEMBER 2001

OPENING SUBMISSIONS OF THE PRISON SERVICE

Introduction

1. The Prison Service deeply regrets the attempted suicide of D on 27 December 2001, and the medical consequences that have ensued for D. Every such event is a tragedy. Systems and procedures have been and continue to be reviewed and, where appropriate, altered. The overriding aim of this process of continuing review – of which this investigation is now a part – is to seek to minimise the occurrence of such events in the future. To that end, since its inception, the Prison Service has co-operated, and will continue to co-operate, fully with the investigation.

2. The immediate trigger for this investigation is the legal obligation on the State under Article 2 ECHR to hold a public, independent investigation into the attempted suicide. In the ordinary course of events, such an investigation would aim to fulfil two main purposes. The first would be to ascertain what had occurred in the period leading up to and after the event. The second would be to see, in the light of the facts, what lessons could be learned.

3. Both purposes will no doubt guide this investigation. However, there are issues in relation to both in the present context. Those issues arise as a result of the very long passage of time that has passed since the relevant events. It is almost 6 years since those events.

4. In relation to the lessons to be learned, the investigation will no doubt be interested in the nature of the changes that have occurred. The present systems, and changes made as a result of and following the D case, are relevant. They indicate the Prison Service taking its responsibilities very seriously and being determined to learn lessons and make the necessary, or desirable, improvements. They indicate fulfilment of this part of the purpose of an Article 2 investigation.

5. This aspect is dealt with in more detail below. At this stage, it is simply to be noted that:

5.1. A series of steps were taken as the direct result of the Draper recommendations. The single sheet headed "Recommendations from Carole Draper's report dated 22 July 2002" was put (without any challenge to its content) before the Administrative Court and the Court of Appeal in the judicial review proceedings. It sets out the steps taken to comply with the recommendations made (a copy is attached as Annex 1).

5.2. There have been a series of further fundamental changes. These are dealt with in the statements of those who deal with the present day (see in particular the statements of Messrs Myers, Gibbs and Warren).

6. However, whilst acknowledging the relevance of these changes in the ways set out above, some caution is needed. Article 2 on no view requires or mandates some sort of wide-ranging investigation into the present systems and practices. The link to the events triggering the Article 2 investigative obligation would have broken a considerable time ago.

7. There are also real difficulties attendant on seeking to expand this investigation outwards to encompass other incidents. There is reference to some such incidents and investigations in Carole Draper's statement. There is one report into the suicide of AD at HMP Pentonville in November 2001 (produced by Carole Draper in June 2002, some six months after D's attempted suicide) in the Bundles at Bundle 9; and there are other reports without any supporting annexes at towards the end of new Bundle 12. It is far too late now to start any attempt to consider at any sensible level of detail those incidents and those reports.

8. In any event, considerable caution is needed in relation to other incidents – particularly, if any attempt is made to use such incidents to support a conclusion of common themes or problems:

8.1. It is very difficult indeed to seek to draw sound parallels between different cases. Each case inevitably turns on its own facts. At most, other cases might illustrate a common problem, or common systems working effectively and well.

8.2. The intensity of investigation in those other cases has not reached the levels of D's case. The facts in those other cases have not been reviewed by the Prison Service for the purposes of this investigation.

8.3. There is no specific evidence as to the steps taken after the internal investigations reported to implement recommendations. There is no reason to doubt that those recommendations were acted on; but it would be a considerable task to trace through implementing steps. And it is highly doubtful that any real value would be derived from that exercise given

8.3.1. the scale and significance of the changes to the systems between 2001 and the present day; and

8.3.2. the fact that every one of the reports (and some of the incidents) occurred after 27 December 2001.

9. In relation to the facts of D's case, the almost 6 year time lag makes it difficult to make confident findings of fact in those areas where what occurred is controversial or in doubt. That difficulty is exacerbated by the fact that regrettably many of the contemporaneous records, although in the main available to Carole Draper, have since been lost.

10. It appears from the suggestions made by D as to appropriate lines of questioning that a central aim of those representing him is to persuade the investigation to produce a report that is critical of those involved at the time.

11. Two points need to be made in relation to that. First, it is clear from the House of Lords' speeches in *Middleton* that it is no part of the purpose of an Article 2 compliant investigation to determine civil, still less criminal, responsibility. Caution is needed not to do by the back door that which would be impermissible in principle by the front door.

12. Secondly, it is also submitted that the investigation will need to be especially careful about making criticisms - particularly of individuals involved.

12.1. Ascribing personal responsibility for the events that occurred, through the making of serious criticisms in a public report, forms no necessary part of an Article 2 compliant investigation.

12.2. The making of any such criticisms is a very serious matter – again, particularly for the individuals involved.

12.3. In areas of doubt or controversy, the investigation should properly be cautious about finding facts that open up potential serious criticism of individuals given the passage of time that has elapsed.

12.4. The need for caution is all the clearer because the investigation will need to be astute to take account of the benefit of hindsight.

13. No doubt the investigation will follow the usual procedures if it is contemplating making criticisms of any body or person.

14. Finally, by way of introduction, it is very important in any investigation such as the present to provide a balanced outcome. Lessons can just as well be learned from what went right in a crisis situation. A public report on the facts of an incident – which will undoubtedly receive significant publicity - should, in fairness to all involved, be as concerned to praise and to acknowledge merit where that is due as it is to criticise.

The approach

15. It is submitted that the investigation will need to consider the following main questions:

    15.1. What were the facts of D's case – in particular, what occurred, and when did it occur; and what did not occur? This is a pure exercise in fact finding, and is at the core of the investigative obligation under Article 2 ECHR.

    15.2. Based on those facts as found, were there things which occurred which should not have occurred, or things which should have occurred but did not? This is a judgemental exercise applying realistic and reasonable approach in the context of a local prison dealing such as HMP Pentonville.

    15.3. Based on the judgements reached, what are the lessons to be learned?

    15.4. To what extent do those lessons remain relevant having regard to the changes that have occurred leading to the present day systems?

16. There is some concern about the way the issues are structured and presented at paragraphs 64-65 of the opening statement of counsel to the investigation. There is at least a risk that they might be seen as over-simplifying the true nature of the issues, and mischaracterising the nature of the Prison Service's position.

    16.1. The fact that a prisoner is able to make an attempt to take his own life does not suggest systemic failings in his care and management. Nor does that fact do so in combination with the additional facts of recognition of risk and F2052SH monitoring.

    16.2. That is not of course to say that the ability to make the attempt may not have been the result of either individual or systemic failings. But no system can provide, or can reasonably be expected to provide, guaranteed avoidance of serious suicide attempts.

    16.3. The implication of the first sentence of paragraph 65 could be that this is the only answer, or indeed the main answer. It is trite that if someone is determined to take their own life, it will be difficult, and perhaps in some cases impossible, to prevent them from doing so. However, the Prison Service acknowledge that this is not an excuse for inadequate systems or individual error or misjudgement; and have never

suggested otherwise. The purpose of systems, and the aim of individuals doing the best they can to care for vulnerable or troubled prisoners, is to do all that reasonably can be done to prevent such attempts, and to react as fast and professionally as possible if such an attempt is made.

16.4. So it is right to say, as the second sentence of paragraph 65 does that the first sentence was not the way the Prison Service viewed the matter. The various Instructions and other documents cited make that clear. However, the acknowledgement that, in summary, all that reasonably can be done to prevent such attempts should be done, does not answer the question whether there were either individual or systemic failings (the question posed at the end of paragraph 64 of the Opening).

Healthcare at HMP Pentonville at the end of 2001

17. The Governing Governor of HMP Pentonville at the end of 2001 was Gareth Davies. He had been in post since June 2001 (Davies statement, para 1). He gives relevant context about Healthcare at paras 5-9 of his statement. As there appears:

17.1. Healthcare was situated in R wing at that time because the old hospital building had been condemned and closed down in around 1994 and no funding had been provided to replace it.

17.2. No-one disputes that R Wing, a Victorian cellblock was not ideal or even suitable as a location for Healthcare. But there was no physical alternative until a new centre was built.

17.3. It is also clear that when Gareth Davies arrived at HMP Pentonville Healthcare was not in good shape. It had been criticised in the 1999 HMCIP report. It had red light status.

17.4. In addition to this legacy, the population presented a serious challenge. As Gareth Davies notes at para 8 of his statement, the prison had to admit, process and accommodate some 9,500 new prisoners a year; and 13% of those had acute psychiatric needs.

18. Gareth Davies focussed on the need to improve Healthcare. He instituted a series of structural changes that he considered were necessary to make Healthcare run effectively (see Davies statement, paras 10-19; and see Attard statement, paras 10-21). In particular, these included the appointment of Mr Monaghan, the head of residence, as a new head of Healthcare; the appointment of John Attard as Mr Monaghan's deputy; and the introduction of significant numbers of additional staff, including in particular a number of prison officers.

19. A series of measures were implemented. These included

    19.1. physical changes to the wing – notably deep cleaning, and the introduction and maintenance of a regime of cleaning; painting and lighting changes;

    19.2. the introduction of a workshop or day centre on one of the wards;

    19.3. a change to the structure of decision making in Healthcare – in effect involving John Attard making management decisions (including about staffing) and Dr Yisa being freed up to make clinical decisions;

    19.4. the recruitment of a new matron, or H grade, called Kay George who is recognised in both the Davies and Hayward statements (paras 28 and 12 respectively) as being a very positive and proactive force.

20. It is clear that the combination of Gareth Davies' determination to improve Healthcare and John Attard's management and organisational skills did have a significant impact in improving both the physical environment in Healthcare and its organisation. One of the consequences of the demonstrable commitment to improvement was the funding of the new healthcare centre that has now been built at HMP Pentonville.

21. There were, perhaps inevitably, some tensions between the new prison officers introduced in 2000 and the healthcare staff who had developed their own ways of doing things. However,

    21.1. there is nothing to suggest that any such tensions adversely affected the care provided to prisoners in Healthcare;

    21.2. it is clear that change was needed, and that the new regime worked considerably better and more effectively than the old.

22. In addition, and importantly, it is clear that the vast majority of the healthcare staff and officers who worked in Healthcare were committed, caring and determined to provide the best environment and care for the prisoners in Healthcare. Gareth Davies refers to the fact that in the early period after he became governor there was concern at the levels of commitment of some of the healthcare staff. But those problems had been dealt with by the end of 2001.

23. The interview with Shirley Boateng at Bundle 2, p 53 et seq provides what would appear to be an accurate and fair overview of Healthcare at the end of 2001 (and one that is consistent with the evidence of the officers and Gareth Davies). As Officer Leane puts it at para 4 of his statement: "It was not ideal but we made the best of it".

24. The daily routine is described in the Hayward statement, paras 44-46.

25. So in December 2001, whilst the physical environment was (and was acknowledged by all concerned to be) far from ideal, Healthcare had made very significant improvements, was being effectively run and managed by committed staff and officers. It was on no view a fundamentally unsuitable environment.

The relevant sequence of events

26. By the date of the attempted suicide on 27 December 2001, D had been in custody on remand at HMP Pentonville for almost a month, having arrived on 30 November 2001.

27. In the period 30 November 2001 to 10 December 2001, D repeatedly threatened self-harm, in fact self-harmed and presented as very disturbed, in the early period of his detention at HMP Pentonville: see Draper, paras 3.1-3.13.

28. This led to a series of steps being taken by those in Healthcare:

28.1. He was admitted to Healthcare on arrival on 30 November 2001 (and he remained there throughout).

28.2. Form F2052SH which had been opened by Securicor at Court was kept open (and remained so throughout).

28.3. He was on 15 minute watch from the outset.

28.4. He was initially admitted to shared Ward 3. He was relocated to a single cell in R1 on 1 December 2001. He was then relocated back to Ward 3 on 3 December 2001.

28.5. 4 December 2001 was a particularly difficult day leading on that day to his emergency sedation, his relocation to the semi-furnished cell (AS3) for a short period and being placed on 1 to 1 watch. He was then relocated back to a single cell in R1 (R1 and H1 are used interchangeably in the records) and remained on 1 to 1 watch.

28.6. He remained on 1 to 1 watch until 10 December 2001.

29. There appeared to be some improvement and settling in the days following 8 December 2001. This led to decisions at case conferences on 10 December 2001 and 11 December 2001 that it would be appropriate to reduce the observation levels to 15 minute documented and then 15 minute supported watch. Indeed, such was the degree to which he had settled that consideration was given at a case conference on 13 December 2001 to relocating him to normal location on an open F2052SH with a support plan.

30. However, in the afternoon of 13 December 2001, he attempted self-harm. He was seen (during the 15 minute watch) tying bedding round his neck. Immediate steps were taken. He was relocated again to AS3 and put back on 15 minute documented watch.

31. Having settled during the rest of that day and the next he was relocated (still on 15 minute watch) back to R1 on 15 December 2001. There followed a relatively long period of stability in which he was settled. There were two incidents, one of head banging on 16 December 2001 and one of throwing things around his cell on 19 December 2001. However, thereafter, he appeared much calmer and participated fully in the regime.

32. On 25 December 2001 he called out to another prisoner that he was going to die that night and told staff that he was not alright, although gave no reason for that. This was noted in the F2052SH. He did not self-harm or attempt to do so. He remained on 15 minute documented watch in R1. 26 December 2001 passed without any incident.

33. It is to be noted therefore that during the period leading up to 27 December 2001:

    33.1. He was the subject of a number of detailed case conferences.

    33.2. There had been a period when D was particularly disturbed when he was placed on 1 to 1 watch. However, there were also substantial periods when he was on 15 minute watch (either documented or supportive).

    33.3. A series of steps were taken to support him, to seek to ease his integration into the regime and to ensure that he was located in the appropriate places.

    33.4. In general terms, he had appeared more settled and to be adjusting to the regime. The early period of his detention had been characterised by frequent incidents of disturbed behaviour and acts of self harm. Those had diminished substantially.

The morning of 27 December 2001

34. This is dealt with in paragraphs 4.1 and 4.2 of the Draper Report. It appears from this paragraph that a noose and a broken razor were discovered in D's cell; and that he said that the noose was intended to be a joke and the razor was for cutting matches. It is not clear from the Draper Report what the source for these matters was. It is assumed that there were entries to this effect in the F2052SH – that record no longer being available. The

Observation book at "PH4" records: "Medication found in cells. Razors and a noose". It indicates that these discoveries were made during the locks, bolts and bars check (also known as the cell fabric check) which took place at 9 am. However, it does not indicate the identity of the person in whose cell the various items were found.

35. It is evident that this discovery was considered and taken seriously by the Officers on R1 at the time. A record was made, along with D's explanation, in the F2052SH. D was and remained on 15 minute documented watch. It is also to be noted both that he himself positively asserted that he had not intended to seek to use the razor or the sheet; and that he appeared to have made substantial progress towards settling into the regime in the period leading up to this.

The events leading to the attempted suicide

36. Officer Leane recalls having promised D a phone call on the morning of 27 December 2001 (Leane statement, para 32).

37. In the afternoon, D is recorded in the Observation book ((PH4) as having been "abusive and aggressive". That record, which is untimed, stated that he had "smashed his locker – claiming that he couldn't stand being banged up any longer". This had apparently been done because the promised phone call had not occurred (see Leane statement, para 32, Leane interview with Ali McMurray at Bundle 2/271). The "action taken or to be taken" column records: "No further action". It is to be noted that this is a reference to disciplinary action. It is evident from the statements of Officer Leane (paras 32-33) and SHO Hayward (para 51) that steps were taken to attempt to calm the situation by providing the phone call.

38. Officer Leane decided that it would still be appropriate for D to have the phone call despite the smashing of the locker. He sought approval from SHO Hayward. That approval was given because SHO Hayward "thought that D might be calmer if he could speak to his girlfriend" continuing "We often find that by making this kind of gesture, we are able to diffuse potentially difficult situations" (Hayward statement, para 51). The approval was given to use the office phone because D did not have his phone card. He spoke to his girlfriend, who (according too what D told Officer Leane after the call) told him that his daughter had been taken into care: see Leane statement, para 33.

39. It is clear that D was distressed as a result of the call. Officer Leane describes him as "distressed and tearful", but notes that "there was nothing extreme about his reaction" and that he "did not think D would try to commit

suicide" (Leane statement, para 34). SHO Hayward, who saw D being escorted back to his cell by Officer Leane, describes him as "quite upset" (Hayward statement, para 52). In his interview with Ali McMurray, SHO Hayward confirmed that he could not remember anything particular that made him think that D was going to do something (Bundle 2/163). Agency Nurse Chikuku's recollection is that, by the time D returned to his cell, he had settled. She said, in interview with Carole Draper (p2),

> "When he came back I went in. He didn't want to speak to nobody but I didn't find any distress in him or in low mood or whatever, he was just the same as he was in the morning ..."

40. Officer Leane locked D back in his cell and then returned to see SHO Hayward in his office. They had a conversation about D:

    40.1. SHO Hayward recalls Officer Leane saying to him that "we should watch out for D because he was upset that his child was being taken into care" (Hayward statement, para 52).

    40.2. SHO Hayward also recalls telling Officer Leane that "we all needed to keep an eye on D". SHO Hayward states that he "would have asked [Officer Leane] to go and tell the staff".

    40.3. SHO Hayward made notes both in the F2052SH and in the Observation book. The latter record survives (PH4) and states: "Apparently his child has been taken into care by social services – already on 15 min watch – staff need to be vigilant". A similar, or identical note, was made in the F2052SH (see Draper Report, para 4.4).

41. The precise timings involved are unclear from the surviving documents and the recollections of those involved.

    41.1. The Observation book records the incident up to D leaving for hospital. That entry is timed at 15.45. It is not known if that was the time of the entry or of the incident.

    41.2. The Draper report states that D was discovered by Agency Nurse Chikuku at 15.30. It is not clear or stated what the source for this was. That report also times the smashing of the locker incident at 15.00.

    41.3. In the interviews a variety of different timings and periods between phone call and discovery of D hanging are put forward (the source of which is unclear).

42. It may be that there is an issue as to the extent of the period between the meeting involving SHO Hayward and Officer Leane after D had been returned to his cell, and D being found hanging.

43. The weight of the evidence supports there being at most a small, if any real, gap between those two events:

43.1. SHO Hayward's recollection is that "the alarm was raised just as I had finished updating D's F2052SH and the entry in the Observation book" (Hayward statement, para 53). In his interview with Carole Draper (p 7) he stated: "Literally from what I can remember, it seems like just after I put the entry in but obviously with the timings there was a little bit of time in between, then I heard the Agency Nurse shout and the whistle go..." In his interview with Ms McMurray, he stated that he did not think it was "too long after" making the entries that the shout went up and whistle was blown – stating in the next answer that "it seemed like seconds" (Bundle 2/161).

43.2. Officer Leane in his statement states that he still would have been in the office with SHO Hayward when the agency nurse shouted for help: Leane statement, para 36. In interview with Ms Draper (p 4) he did not suggest any significant time gap. He put the time of the entry in the F2052SH at about 3.00 ish, and then went straight on to describe getting the shout from Agency Nurse Chikuku. In interview with Ms McMurray Officer Leane initially thought that there had been a more significant time lag of between 30 minutes and an hour; but was unsure, commenting when SHO Hayward's recollection was put to him that "maybe it was..." (as SHO Hayward had described it) although it seemed longer to him.

43.3. Agency Nurse Chikuku's recollection in interview with Carole Draper (p2) is that there was a maximum of 10 minutes between D arriving back at his cell and her doing her next check and discovering him hanging.

44. The main suggestion that appears to be made on D's behalf is that more could and should have been done after the phone call. Two particular matters are focussed on.

45. First, a question has been raised about whether or not Agency Nurse Chikuku was told to be particularly vigilant following the entry in the F2052SH. As to that:

45.1. She stated in interview with Carole Draper that she was not told anything about the telephone call by Officer Leane (see p 2). SHO Hayward recollects asking Officer Leane to tell staff about the need to be vigilant. Officer Leane does not recollect telling her.

45.2. However, if, as appears most likely for the reasons set out above, Officer Leane had not left the office following his discussion with SHO

Hayward by the time the alarm was raised, that would explain this. He wanted to discuss what action to take with his senior officer, and had only just done so when the alarm went off. There was therefore no failure to pass on the substance of the record made in the F2052SH and the Observation book. There was simply no opportunity to do so.

46. In any event, the following matters are to be noted:

    46.1. Agency Nurse Chikuku was already doing documented 15 minute watches. It is to be emphasised that that does not mean that she was simply or merely regularly checking every 15 minutes. She was doing such watches on the same corridor in relation to a maximum of six people (see her Draper interview at p 2, first line) whose cells were next door to each other. The requirement was to document every 15 minutes. The irregular checks were more frequent than that. Her evidence is that there was a period of no more than 10 minutes between seeing D on his return after the phone call and her returning on her checks.

    46.2. There is no reason to suppose that she was not conducting those checks vigilantly and carefully. On the contrary, she discovered the paper over the hatch and then that D was hanging. And, importantly, when she did so must have been a short time after he hanged himself because officers were able to resuscitate him.

    46.3. It also appears from her interview with Carole Draper (p2) that Agency Nurse Chikuku was aware (whether from talking to D or to his neighbour is not clear) that D had spoken to his girlfriend.

47. Secondly, a question has been raised as to whether D should have been put on 1 to 1 watch after the phone call. If the timings are as set out above, this suggestion is simply theoretical. There was no time to make the judgement call and implement it before the alarm went up. That is therefore a complete answer to this point.

48. In any event, it appears from SHO Hayward's interviews and statement that the course of action he believes he would have followed (if he had had the time, which he did not) would have been (a) to talk to D about increasing the level of observations; (b) to inform those doing the 15 minute documented watch and other staff to be extra vigilant; and then (c) to discuss D's case with the doctor next time he did his rounds later in the afternoon. It is to be noted in relation to (a), that some prisoners would have been very resistant to 1 to 1 watches because of the level of intrusion involved. It by no means follows that because at an earlier stage there had been 1 to 1 watches D would have been content for such watches on 27 December 2001. 1 to 1 watches have their own problems (see eg Gibbs statement, para 33).

49. Any decision by SHO Hayward would have been a judgement call. It would have been an entirely reasonable and proper one for an SHO such as SHO Hayward to make. It would have been a judgement

    49.1. that responded to the recent event of the distressing phone call, in the context of D's history including both the numerous incidents of self harm that had occurred but also the apparent recent settling into the regime;

    49.2. that would have involved direct engagement with D in the form of a talk with him by SHO Hayward; and

    49.3. that would have involved discussing his case (no doubt better informed as a result of the talk with D) with those with medical expertise.

50. The judgement would have been informed by the level of the discussion between SHO Hayward and Officer Leane, on an intimate and detailed knowledge of D built up over the preceding month, during the entirety of which D was in Healthcare. That knowledge would have been derived from knowing and interacting with D whilst in Healthcare, from the contents of the F2052SH and the Observations book, and from the daily handover meetings, which were designed to, and were effective to, ensure that all relevant information (including that on the F2052SH) was available to and known to those responsible for the care of the prisoners. The judgement would also have been based on long experience of dealing with and assessing prisoners in a similar situation to D. SHO Hayward had been in Healthcare for over 10 years by December 2001, the last 3 years as SHO (Hayward statement, para 2).

51. Carole Draper concluded that some staff appeared uncertain as to those who had authority to determine appropriate levels of observation (her sixth recommendation dealt with in the Draper statement, para 31). In considering the sequence of events, it needs to be borne in mind in this respect that SHO Hayward was quite clear that he had the authority to increase the 15 minute to a 1 to 1 watch if he judged that to be appropriate: see Hayward statement, paras 35 and 53 (second sentence).

52. Finally, on this point, it is far from clear whether, even if there had been time for constant observations to be implemented, such a decision would have been effective to prevent D attempting suicide. If a person is determined to make such an attempt, it is possible to find a way to do so even on 1 to 1 watch.

53. In short, it is submitted that, even if it is concluded (contrary to the primary submission set out above) that there was some time lag between the conversation between SHO Hayward and Officer Leane, the evidence suggests that SHO Hayward's thinking was as set out above. It would be deeply unfair and wholly unjustified to criticise him for deciding not to put D on constant observations .

The saving of D's life

54. It is no exaggeration to say that the prompt action and professionalism of all those involved in the immediate reaction to the alarm saved D's life. In particular, SHO Hayward, Officer Leane, Officer Richards and Officer Murray are to be singled out.

55. The sequence of events is set out in Hayward statement, paras 55-60; Leane statement, paras 37-42 and Richards statement, paras 41-45:

    55.1. Agency Nurse Chikuku raised the alarm.

    55.2. Officer Richards was first on the scene. He arrived a few seconds after the alarm was raised, unlocked the cell and immediately supported D's weight from the waist whilst trying to get his hand up to support the head and neck.

    55.3. He was joined seconds later by Officers Murray and Leane and SHO Hayward.

    55.4. Officer Murray assisted Officer Richards in supporting D. Officer Leane and SHO Hayward got onto the bed to attempt to undo the knotted sheet.

    55.5. SHO Hayward shouted for the anti-ligature scissors. Agency Nurse Chikuku was unable initially to find them. However, SHO Hayward told her that they were in the emergency response kit bag which was kept in a cell only some 15 yards away; and the bag was produced quickly after that (Hayward statement, para 55).

    55.6. SHO Hayward had to get off the bed to open the bag which appears to have been thrown into D's cell. He was annoyed that he had to do so, but judges that that "did not delay us more than a few seconds" (Hayward statement, para 55).

    55.7. D was then cut down. He had no pulse and was not breathing. The work done by the officers brought him back, so that when he was transferred into the care of the emergency services and thence to hospital he had a pulse and was breathing without aid. These are set out in the Hayward statement, paras 56 and 57.

56. The promptness and professionalism of the response had much to do with SHO Hayward. He decided that he wished to train himself to deal with emergencies of the kind that occurred in Healthcare. He did so, sometimes paying for it himself. He then sought backing from Dr Yisa (which was given) for him to do the instructor's course on a trauma course know as Basic Trauma Life Support. He persisted in his desire to introduce this training into HMP Pentonville. He was supported by all of Dr Yisa, Gareth Davies and John Attard. He then ran his training course in HMP Pentonville. His dedication and persistence resulted in there being enough staff trained as Emergency Medical Response Team (EMRT) members for such teams to be available on every shift. The EMRT went live in July 2001. The call sign was "Hotel 9". (See generally Hayward statement, paras 16-24).

57. The result was that when D's emergency arose on 27 December 2001:

57.1. There were trained officers on hand who knew what needed to be done immediately and in the time before emergency services could arrive. That team was headed by its architect, and most experienced member, SHO Hayward.

57.2. There was on the wing an emergency response bag with all the necessary equipment already packed into it.

57.3. The available expertise and equipment enabled all that could be done to assist D to be done, both speedily and effectively.

Training

58. The extent of training will always be the subject of some controversy. Resource issues are raised. Judgements need to be made in a context where resources are tight and other priorities are pressing. The core issue however in a context such as the present is whether training, or any alleged lack of training in a particular area, materially contributed to the outcome.

59. It also needs to be borne clearly in mind that training sits alongside practical experience. Officers and staff were dealing with a very large number of sometimes very troubled prisoners on a daily basis. Many, as for example SHO Hayward points out at para 15 of his statement, were self-harmers. Practical lessons learned on the job, and the experience of dealing with the wide range of prisoners going through Healthcare, were just as valuable as training in ensuring that good judgements were made in deciding how to react to a difficult situation.

60. The EMRT has been dealt with above (see generally Hayward statement, paras 17-25; Leane statement, para 14; Richards statement, paras 15-17). The

training undertaken by SHO Hayward, first of himself and then, as instructor, of other officers on the EMRT was a, if not the, central reason in the reaction to the incident being as speedy, professional and successful as it was. Officer Richards described the trauma training he received when he first joined Healthcare (in October 2000) as "brilliant": Richards statement, para 18.

61. As appears from the Hayward statement, para 15, EMRT training was only one of the aspects of the ongoing training of those at Healthcare. SHO Hayward instigated a series of training afternoons specifically designed for those who worked in Healthcare. Those training sessions were run either by SHO Hayward or by the lead nurse

62. Suicide awareness and suicide prevention training was available at HMP Pentonville. SHO Hayward recalls that there were half or full day courses available with a rolling refresher programme on Wednesday or Thursday afternoons (Hayward statement, para 14). He also recalls that there was a "prison wide push to get everyone trained in Suicide Prevention" (para 14). Officer Leane is sure that he would have done some training on suicide and self-harm awareness (Leane statement, para 16).

63. This is an area where practical experience and judgement is of paramount importance. It is evident that all of the officers in Healthcare regarded interaction with disturbed prisoners as being of particular importance: see eg Hayward statement, para 27. There is also obvious force in SHO Hayward's statement: "The best means of assessing whether a prisoner is at risk is to look at the individual in front of you" (para 42).

64. There was also specific training on the F2052SH form. SHO Hayward for example attended a module on this in 2001 (Hayward statement, para 14).

65. Whether as a result of training or as a result of practical experience of its use, those involved in D's case were fully aware of how the form should be used. A description of the process for the identification, assessment and care of self-harmers is set out in the Hayward statement, paras 28-32. Indeed, from the Draper Report, it appears that the form was in fact properly used to record the various incidents and other matters.

66. It is to be noted in addition in this respect that the F2052SH was not simply filled out as a form filling exercise. Effective steps were taken to ensure that those responsible for the prisoners in Healthcare were kept abreast of developments.

66.1. There were daily briefings at the morning handover meetings.

66.2. Officers also read the F2052SH so that they knew about those who they were caring for in Healthcare: see eg Leane statement, para 18.

66.3. There was the Observation book in which matters of importance were also noted.

66.4. There was the board in the office which highlighted particular matters about particular prisoners (see Richards statement, para 33).

67. In these circumstances, it is submitted that the investigation should find that training was available and was undertaken in the skills relevant to dealing with cases such as D's. In particular, the trauma and EMRT training was evidently both of a high standard and an important factor in saving D's life.

Probation, Chaplaincy, Samaritans

68. It appears from the records available to Carole Draper that D was referred to the Chaplain and Samaritans on 3 and again on 4 December 2001; and was then referred to the Samaritans and Probation on 13 December 2001.

69. It is not known whether he saw any of those bodies. In the absence of any record to that effect, Carole Draper concluded not: see eg Draper Report para 6.2.1. However, the absence of a record does not necessarily indicate that he did not see any of those bodies. The manner in which he would, or might, have done so can no doubt be explored with witnesses. It is understood that, in relation to at least some of them, access was easy and could be informal.

70. If these referrals did not in fact result in D seeing Probation, Chaplaincy and the Samaritans, it is acknowledged that they should have done.

71. Carole Draper's report is critical in particular of the fact that Probation were not involved given the concerns expressed by D about his daughter whilst in healthcare (para 6.2.3 of her Report). As to that:

71.1. As set out above, it is not clear whether D did or did not see Probation. Given that a reference to probation was made on 13 December 2001, it is acknowledged D should have seen Probation.

71.2. It is to be noted that no-one knew about the possibility that the daughter might be taken into care until the call on 27 December 2001. There is no evidence to suggest that that was anything other than a shock to D.

71.3. As set out below, probation are now actively involved. Probation officers are based in HMP Pentonville itself (Warren statement, para 13).

Psychiatric referrals

72. It is acknowledged that D should have been seen by a psychiatrist during his month at HMP Pentonville; and was not. The reasons why that occurred are not entirely clear. He was seen however by a psychologist, Dr Halsey on 18 December 2001. He scheduled to see D again in the New Year.

73. It is to be borne in mind that this psychiatric resource was in considerable demand. Many thousands of prisoners flowed through this large local prison. And a significant proportion of those had, and have, acute psychiatric need.

74. The position at this stage is that Dr Yisa and Dr Ranaweera will not give evidence until Professor Rogers and a responsive expert are heard (in September). In those circumstances, what follows in this section is to be treated as provisional only and subject to the evidence that they are to give.

75. The relevant facts, as they appear from the Draper Report and the records to which she had access, are as follows:

75.1. D was referred to a visiting psychiatrist by the doctor or saw him at 17.30 on 30 November 2001, the day he arrived at HMP Pentonville.

75.2. On 3 December 2001, he was referred to a visiting clinical psychologist for counselling and a visiting psychiatrist for mental assessment by the doctor who took his full history. At 21.15 on that same day he was referred urgently to a visiting psychiatrist after barricading himself in his cell and self-harming by lacerating both arms with a piece of porcelain from his toilet.

75.3. On 4 December 2001 Dr Yisa again requested urgent referral to a psychologist and psychiatrist following the self harm and emergency sedation on that day. That referral was repeated at the case conference later in the day. It appears (see Draper Report, para 6.2.1) that a written referral to a psychiatrist was generated on this date.

75.4. He was listed to see psychiatrist, Dr Akinkunmi on 5 December 2001. He was not seen by Dr Akinkunmi on that date. It is not known why that was so.

75.5. By the morning of 13 December 2001, D appeared to be settling into the regime. The case conference that day noted that he was to be assessed by the visiting psychologist and psychiatrist in the out-patients department when arranged (see Draper Report, para 3.16).

75.6. D was seen by psychologist, Dr Halsey on 18 December 2001. He considered that D required thorough psychiatric evaluation and listed him to see the visiting psychiatrist. This led to a written referral dated 19 December 2001 (see Draper Report, para 6.2.1).

75.7. Again, the psychiatric evaluation did not take place. It is not known why that was so.

76. It is not known at this stage whether steps were, or would have been, taken to follow up these referrals. Carole Draper stated that she had not been able to discover whether these referrals "were followed up by external departments"; noted that she had only been able to discover the 2 written referrals set out above; and noted that on neither occasion did there appear to have been any follow up by staff as to why he was not seen or any attempt for him to be re-listed to be seen by someone else at a later date. It is to be noted that her conclusion appears to be based on the facts that (a) there were limited records on this issue and (b) no-one had been able to provide an explanation for the missed appointments or a recollection of follow up action. It is also to be noted that this issue was not explored in any depth in her interviews.

77. Mr Attard describes the system of referrals at paras 24-8 (Bundle 3, Tab 9). In summary, as there appears:

77.1. Prisoners would be referred by the doctor to outside psychiatrists and psychologists.

77.2. In 2001, HMP Pentonville used psychiatric services from Camlet Lodge on a sessional basis. Each specialist would attend roughly once a week to see and assess their patients. So if an appointment was missed the prisoner would have to wait until the next time the specialist was in the prison.

77.3. There were many reasons for appointments being missed. Other appointments may have cut across. It is to be noted that the "did not attend" rate at HMP Pentonville is around 40% (see Attard statement, para 25).

78. Others have referred to the system of referrals at the relevant time – see eg Shirley Boateng at Bundle 2, p 68 et seq. None regarded the system as inadequate or systemically flawed.

79. Accordingly, it appears at this stage (and, it is repeated, subject to the evidence to come at a later date), that:

79.1. There was a system in place designed to ensure that prisoners saw the visiting psychiatrists and psychologists on referral from doctors working in the prison.

79.2. Built into the system was the ability for people to be seen on a more urgent basis (see eg Shirley Boateng, at Bundle 2, p 68, last 2 lines).

79.3. There are many reasons why appointments might have been missed. It is not clear why that occurred in this case.

79.4. Neither records nor recollections are, or were by the date of Carole Draper's investigation, available to answer the further questions whether there was any follow up to ensure that those who missed appointments had other opportunities to see the necessary specialists; and, if so, why that did not succeed in getting D before a psychiatrist.

Documentation

80. There were a number of document streams, including in particular the IMR, the F2052SH, and the Observation book and the nursing care plan. Carole Draper concluded that the document systems were "chaotic and inefficient" (Draper Report, para 6.9).

81. It is plain and acknowledged that it was and is important to have a system which ensures that records that are made on prisoners in Healthcare are properly retained and stored so as to be accessible to those who need to make decisions about care. The difficulties of ensuring accessibility of the streams of required medical record (notably IMR and F2052SH) in all circumstances in a prison dealing with the sheer numbers of HMP Pentonville need to be borne in mind.

82. Three points are to be noted on this issue:

82.1. It is not suggested by Carole Draper that this inefficiency had any material impact on D's case. Nor could that be suggested now. There is nothing to indicate that the F2052SH form was not available when decisions needed to be made. In particular, it is clear that, on 27 December 2001, the F2052SH and the Observations book were where they should have been; and were available to those on duty that day.

82.2. Following Carole Draper's final recommendation there was a general review of documentation systems in healthcare aimed at ensuring accurate maintenance and ease and security of location.

82.3. The paper systems are on the verge of being replaced by a new electronic system, EMIS (see below).

Lessons learned and the present day

83. It is evident from the single sheet showing the implementation of the recommendations of Carole Draper that her recommendations were taken forward, and the appropriate lessons learned and changes made.

84. The main developments since December 2001, both nationally and at HMP Pentonville, are set out in the statements of Michael Gibbs (Deputy Head of the Safer Custody Group at HMPS), Nigel Myers (Safer Custody Manager at HMP Pentonville) and Jonathan Warren (Healthcare Manager at HMP Pentonville). Major changes have taken place.

85. At the national level:

85.1. The ACCT system has been developed, and was brought into operation in 2005-2007. Its development, aims, advantages and implementation are described in detail in the statement of Michael Gibbs. It has replaced the F2052SH system (for a comparison of the two systems, see Myers statement, paras 25-29). It was accompanied by a huge training commitment (see Gibbs statement, para 17). It is now in its fourth version.

85.2. There is a new Prison Service Order, PSO 2700, which consolidated existing suicide prevention instructions with known good practice. It took effect on 1 January 2003. It is described in the Gibbs statement at para 21 et seq. A revised version is currently being worked on and should take effect towards the end of 2007.

85.3. A research number of studies have been commissioned. Notable amongst them is the study to compare the operation of the F2052SH and the ACCT systems (see Gibbs statement, paras 27-30).

85.4. The issues surrounding suicide prevention are continually being monitored and reviewed with an eye to seeing if current systems and practices can be improved (see Gibbs statement, paras 30-31 and 38). It appears that the bare statistics at least indicate an improvement: see Gibbs statement, paras 36-37; and, for HMP Pentonville, see Myers statement, paras 31-32.

86. At HMP Pentonville:

86.1. ACCT was launched in October and November 2005 (Myers statement, para 5). A detailed description of the processes involved in ACCT is set out in the Myers statement, paras 6-17. An intensive training programme preceded that introduction. Basic ACCT training is given to all new entrant prison officers at the Prison Service College; and half a day is then spent with Safer Custody Group for all prison officers arriving at HMP Pentonville. In addition, 25 officers and staff have been trained as ACCT assessors. Regular refresher training is provided (See Myers statement, paras 18-23). Nigel Myers conducts a review of all open ACCT plans on a weekly basis to ensure that meaningful entries are

being made. He also liaises with and reports monthly to a Suicide Prevention Committee (Myers statement, para 29).

86.2. Aside from the ACCT training, there is a considerable range of both mandatory and optional training: see Warren statement, paras 22-23.

86.3. There is now a new Healthcare Centre, which is described by Jonathan Warren as "a pleasant, clean, safe and bright environment" (Warren statement, para 5). The staffing and running of it are described in the Warren statement, paras 5-9.

86.4. HMP Pentonville now has a dedicated mental health in-reach team. Those on this team (including a consultant psychiatrist 4 days a week) are set out at Warren statement, para 10.

86.5. The system of referrals is "single point of entry" (ie anyone can refer a prisoner to the team). It is described at Warren statement, paras 11-12, and, so far as psychologists are concerned, para 14.

86.6. Probation officers are based in HMP Pentonville itself (Warren statement, para 13).

86.7. The system of watches/observations of prisoners in need of this is set out in Warren statement, paras 15-16. In particular it is to be noted that the 15 minute documented watch system has been replaced by, at that level of observation, 5 irregular watches in an hour.

86.8. The system for emergency responses, which continues to use the Hotel 9 call sign is described in Warren statement, para 17-19 and 21 (which confirms that all prison officers now carry cut-down knives, called the "Big Fish").

86.9. The Carole Draper concerns about after incident debrief and support have been dealt with: see Warren statement, para 20.

86.10. The problems of maintaining and ensuring access to a variety of streams of physical records are being dealt with as HMP Pentonville moves towards a full electronic prisoner medical record system called EMIS: see Warren statement, para 27.

Conclusion

87. The position today, both nationally and at HMP Pentonville, is undoubtedly improved. All the steps set out above have contributed to that improvement. Those steps reflect a determination to seek to make prison, and HMP Pentonville, safer places providing better care and management of at risk or vulnerable prisoners. These steps, and this improvement, should be fairly and fully acknowledged in any report. To the extent that lessons needed to be learned, they have been learned and appropriate changes made.

88. The evidence now before the investigation indicates a range of real and important positives. By way of example only:

88.1. The determination of Gareth Davies and John Attard to drive forward improvements in Healthcare in 2000 and 2001 produced results. Healthcare was a cleaner, more efficient and more effective place by the time D arrived at the end of November 2001.

88.2. By that time, those who ran Healthcare comprised dedicated and caring staff. John Attard was at or close to the top of the management chain. Dr Yisa was in charge of the clinical side, and was well respected in that role. Kay George was in post as the new matron, supported by the likes of Shirley Boateng. There were a number of hand picked (by John Attard) officers working in Healthcare. One of the senior officers was SHO Hayward.

88.3. SHO Hayward is (and was) plainly an outstanding officer. He put himself through a series of courses of direct relevance to the way the team reacted on the afternoon of 27 December 2001. He then drove forward the setting up and training up of the EMRT. He was the senior officer on duty throughout 27 December 2001.

88.4. Those responsible for D were properly and adequately trained, and were also experienced.

88.5. The processes for recording serious incidents on the F2052SH and ensuring (eg through morning handover meetings) that relevant information was passed on to officers and Healthcare staff appear to have been working well.

88.6. There is no reason to suppose that proper and justifiable judgements were not made about the level of observations needed at any particular time in the period leading up to 27 December 2001 (and on that day see the detailed analysis above, summarised below).

88.7. Agency Nurse Chikuku discovered D. She did so making a check 10 minutes after she had last seen him. This indicates that the 15 minute documented check system was operating properly and well, with irregular checks at greater frequencies than 15 minutes. It is highly probable, because the officers were able to revive him, that D had only been hanging a short time before he was discovered.

88.8. The reaction to the discovery of D hanging in his cell is deserving of high commendation. The team of officers, trained and led by SHO Hayward, reacted with speed and professionalism. Everyone assisted. Officer Murray was right to say to Carole Draper: "He (D) was dead and we brought him back" (p 4 of Draper interview).

89. For all the reasons set out above, there is no basis for criticism of the officers concerned. In particular, any suggestion that, at the time of his attempted suicide, D should have been on 1 to 1 watch would be unsustainable on the evidence. That is in summary because:

89.1. The history on and leading up to the phone call on 27 December 2001 did not warrant it.

89.2. Once the phone call was made, there was little or no real time to make the decision to change the 15 minute documented watch to a 1 to 1 watch. The alarm was raised when Officer Leane was still in the office with SHO Hayward, and a matter of a few minutes from the time when D was returned to his cell. In any event, SHO Hayward's judgement would have been not to alter the level of observation – at least before discussing matters with D and probably also talking to the doctor on his round later in the afternoon.

90. In the circumstances, there is no basis for criticism of the individual officers and staff who dealt with D in Healthcare at HMP Pentonville. To the extent that systems could have been and needed to be improved, the requisite steps were taken. The regime and the systems are in any event now fundamentally different. But it is evident that the lessons have been learnt.

6 July 2007

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