First Witness Statement
Her Majesty's Prison Service
29 June 2007
Exhibit CD1-CD3

Prisons and Probation Ombudsman | **Investigation no 01/2007**

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

WITNESS STATEMENT OF CAROLE DRAPER

I, Carole Draper of ***Her Majesty's Prison Parkhurst, Clissold Road, Newport, Isle of Wight, PO30 5NX*** WILL SAY AS FOLLOWS:

1. I am the Governing Governor of Her Majesty's Prison Parkhurst. I did not meet Mr D but was the Governor commissioned to carry out an internal Prison Service investigation into the circumstances surrounding his attempted suicide at Her Majesty's Prison Pentonville ('HMP Pentonville') on 27 December 2001. I am aware of the terms of the current investigation and I am happy to assist the Prisons and Probation Ombudsman in his investigations wherever possible.

Background and qualifications

2. I joined the Prison Service in September 1984 under the Assistant Governor Trainee scheme. During my traineeship, I spent time at Her Majesty's Prison Holloway ('HMP Holloway') and at HMP Pentonville as well as attending training at the Prison Service College. After I qualified, I remained at Pentonville as a wing Governor until mid 1988. I then became the Residential Governor of Swaleside training Prison on the Isle of Sheppey. I went on to become the Deputy Governor of Cookham Wood Prison in 1992. In 1994 I took up the role of Staff Officer to the Area Manager for London North. I then spent two years as the Healthcare Manager at HMP Holloway. In 1998, I briefly returned to Head Office as a Staff Officer to the Area Manager for London North.

3. In May 1998 I became third in command of Her Majesty's Prison Wormwood Scrubs ('HMP Wormwood Scrubs') and in 1999 I was promoted to the post of Deputy Governor there. In May 2001 I became a Senior Investigating Officer at the London Area Office where I was appointed to undertake any investigation commissioned by the Area Manager. My remit covered a wide range of investigations under the Prison Service Code of Discipline as well as preliminary, fact-finding investigations, known as simple investigations and death in custody investigations. However, in reality, I was mainly allocated deaths in custody investigations. In March 2003 I became the full time Resettlement Advisor for the London Area Office. From 2004-2006 I was the Manager of the Haslar Immigration Centre until I took up my current post in February 2006.

Prison Service internal investigations and reviews

4. I attended a 5-day training course for Senior Investigating Officers at the Prison Service College between 9 and 13 March 1998. This course was the first of its kind into deaths in custody and was designed and taught by trainers and governing Governors who had experience of conducting death in custody investigations. I think that the training came about as part of a Prison Service wide initiative to enhance the professionalism with which the Prison Service handled death in custody investigations. The training was very useful and all the officers were provided with a series of notes explaining how an investigation should be carried out. The training gave advice on the practical consequences of dealing with a death in custody including liaison with coroners.

5. When I was appointed Senior Investigating Officer at the London Area Office in May 2001, my remit was to undertake investigations commissioned by the Area Manager. The vast majority of the investigations that I undertook were into deaths in custody. I conducted investigations at Feltham Young Offenders Institution as well as Her Majesty's Prisons Belmarsh, Wandsworth and Wormwoods Scrubs as well as at HMP Pentonville but I cannot remember now how many investigations I conducted overall. The general purpose of these investigations was to consider the facts and circumstances surrounding the death or act of serious self-harm and to use my findings to highlight any areas for concern and any learning points for the prison and the Prison Service as a whole. At the time of D's attempt on 27 December 2001 I was conducting two on-going death in

custody investigations, both of which were at HMP Pentonville. These were into the self-inflicted deaths of Mr AD and Mr CM.

6. In January 2002, the Head of Investigations at the London Area Office, Ifor Smout, asked me to undertake a further formal investigation at HMP Pentonville into the death in custody of Mr SC on 28 December 2001. It was at this time that he also asked me to conduct a review of the facts and circumstances surrounding D's attempted suicide. This review was not identical to a death in custody investigation as it did not have any specific terms of reference and it was not registered with the Investigation Support Unit. However, as I was conducting formal investigations in the deaths in custody at HMP Pentonville, I agreed with Ifor Smout that I would follow the same procedures that governed formal death in custody investigations. In 2001, the procedures governing these death in custody investigations were contained in Prison Service Orders 1300 and 1301.

7. In 2001, it was standard practice that there would usually be an internal investigation following a serious incident of self-harm. However, the prisons usually carried out these investigations so that they could identify any lessons to be learned themselves. As far as I am aware, I was asked to carry out the investigation in to D's attempt for two reasons. Firstly, that this was a very serious attempt and secondly, because I was already at HMP Pentonville conducting two on-going death in custody investigations and would be commencing a third investigation into the circumstances surrounding the death of Mr SC. This made good sense to me, not least as a lot of the same members of staff were involved in both cases. In fact, I interviewed Officers Leane, Murray, Richards, Senior Officer Hayward and Dr Yisa in connection with both investigations simultaneously. I believe that the decision to commission me to investigate Mr D's attempt was welcomed by both the Governor and the staff at HMP Pentonville, who could see the economies of scope to investigating both of these cases simultaneously.

General methodology

8. Before I started any investigation into an act of serious self-harm or death in custody, I would write to the prison requesting sight of all the relevant documents. I have drawn up a general list of the documents that I would normally request in order to assist the Prisons and Probation Ombudsman. It is drawn up to the best

of my recollection but should not be relied on as a definitive list as I have not conducted an investigation since 2002. This list of documents is now produced and shown to me as **exhibit CD1**. The list of documents I would request generally included the incident reports and statements of any officers and nurses involved, the prisoner's core record, Inmate Medical Record ('IMR'), care plan, self harm at risk form ('F2052SH') and any documented watch sheets. I would ask for details of the prisoners in the nearby cells and those who knew the prisoners so that I could interview them. I would also obtain copies of the control room logs, staffing detail and Observation Book. It was also my practice to request copies of the prison's local policy on suicide and self harm, the minutes of the Suicide Prevention Committee's meetings in the three months leading up to the incident and documentation from the probation, chaplaincy or education units if they had had any dealings with the prisoner. I would also request copies of other death in custody reports as well as the Prison's contingency plan for a death in custody.

9. Once an investigation was underway, I would often conduct a review of the suicide and self-harm procedures in place and would check that these procedures were compliant with national policy. I would also ask for copies of recent Her Majesty's Chief Inspectorate of Prisons reports, standards audit reports, reports from other deaths in custody and their action plans as I found that they helped me to build up an overall picture of the standard of compliance in practice and of the lessons learnt by the establishment in question. For example if the establishment had a local policy of conducting an initial F2052SH review after the form had been open for 24 hours and then further reviews at 72 hours and 7 days, I would check a sample of F2052SH to ensure that this policy was being followed in practice.

10. Once I had received this documentation, I would first draw up a time line, which would start from when the prisoner came into custody and cover the incident as well as the post incident period. On this timeline I would mark all significant events in the prisoner's records and significant dealings with members of staff. I found that this was an extremely helpful exercise, as it enabled me to decide which members of staff and prisoners I should interview.

Other investigations at HMP Pentonville

11. During 2001 I conducted investigations at HMP Pentonville in to the death in custody of 2 other prisoners: Mr CM on 10 October and Mr AD on 3 November. I was also aware that there had been three earlier deaths at HMP Pentonville in 2001, that of Mr RM on 19 January, Mr BW on 25 January and Mr IB on 25 May. There had been a cluster of deaths in custody at HMP Pentonville during 2001 in a very short space of time. From my experience in the Prison Service, it does appear to me that this can happen in a prison from time to time for no ascertainable reason and I know that these clusters have been seen in other prisons such as Reading and Cardiff. Reports into deaths in custody were generally filed within 6-9 months of the prisoner's death and so the reports in to the deaths of Mr CM and Mr AD were completed and filed after D's attempt on 27 December 2001.

12. The reports into the deaths of Mr RM and Mr IB were filed on the 2 and 3 October 2001 respectively. The key recommendations from these reports were largely procedural, for example that Governor grade checks on F2052SHs should be tightened up and there should be more follow up to trace F2052SHs that did not return from court with an inmate. The IB report also advises that priority be given to suicide awareness training and the relocation of the emergency bag so that it could be swiftly accessed by staff on night duty. I believe that the key recommendation from the BW report was that efforts be made to ensure that F2052SH reviews in healthcare should be multi-disciplinary.

The D review

13. In order to review the facts and circumstances surrounding D's attempt, HMP Pentonville provided me with several key documents. As I was already investigating two other deaths at HMP Pentonville, I already had a number of documents relating to the prison itself. In addition to these, I would have received copies of D's core records (known as the F2050), his IMR and F2052SH. I also requested the incident reports completed by the staff on duty that day. I note that there is no incident report from nurse Chikuku. Unfortunately, I cannot remember if nurse Chikuku completed an incident report at the time of D's attempt but feel that if she had not completed a report at the time, I would have asked her about this when I interviewed her. The documents relating to the provision of

healthcare at HMP Pentonville were annexed to the report into the death in custody of Mr Duffy, which occurred on 3 November 2001. I have not retained copies of these documents.

14. I found the staff at HMP Pentonville to be very helpful in my investigation. They were very open with me and gave me their frank, upfront opinions. The staff involved were very concerned about D's condition and a lot of them were mortified that they had not been able save him from permanent injury. I did not interview prisoners in this case because I was not conducting a formal investigation and felt that I had obtained enough information about the facts and circumstances surrounding D's attempt from the interviews that I conducted with the staff.

15. I interviewed the members of staff involved in D's attempted suicide at HMP Pentonville using a PACE machine which is able to record two tapes simultaneously. After each interview I would seal the master tape in the presence of the member of staff and both I and the member of staff would sign the seal. We would then repeat this process with the copy. One copy of the tapes was sent to the London Area Office to be transcribed. I kept the transcribed copies of the tapes as well as the masters together with copies of all of the documentation relating to the investigation in box files, which were primarily kept in London Area office. Once the interview transcripts had been prepared, copies would be sent to the interviewees for their review and signature. They would then return a signed copy of their transcript to me.

16. Once I had decided on the recommendations that I wanted to make, I would informally feed these back to the prison before I submitted my report to the London Area Office. The Area Office would then formally send a copy of the report to the prison and the prison would draw up an action plan based on my recommendations. I do seem to remember that as I had conducted a few investigations at HMP Pentonville in 2001 and that Abi Sheik had also conducted an investigation during that period, our recommendations were put into a joint action plan. Once the action plan had been drawn up, I believe that the Governor and the Area Manager were planning to monitor its implementation at the prison.

17. I was not usually involved in the follow up with an individual prison after I submitted the report of an investigation so I am not sure what the practice was at

the Area Office. I have not returned to HMP Pentonville since I filed my report, so I cannot comment on how the recommendations made in my report on D were implemented.

Care and handling of report post completion

18. Once my report was complete, I handed all of the copy documents and records, transcripts, tapes, discs and unused material to Stuart Salmon, who was an Administrative Officer at the London Area Office in 2001/2. He would then follow the standard operating practice in place at the London Area Office at that time. This was to secure the information and send it to the Investigation Support Unit where it would be registered and put into safe storage. I understand that this did not happen in this case as my review of the circumstances surrounding D's attempted suicide was not a formal death in custody investigation and was never registered by the Investigation Support Unit.

Format of report

19. In the introduction to my report, at paragraphs 1.1-1.5, I set out the purpose of my report and explained why I had only been able to file it on 22 July 2002. I further stated that I had not included a review of self-harm issues as I had covered these in the AD and CM investigations. This review is now produced and shown to me as **exhibit CD2.** I compiled this review from the information made available to me by HMP Pentonville. The review lists the dates of incidences of serious self-harm and where they were reported. I have set out the findings of this review on the final page. This review generally revealed poor co-ordination and records management in the healthcare centre, although I did note that there had been an improvement in reporting procedures in the later part of the audit period due to the introduction of improved reporting procedures at HMP Pentonville.

20. In Chapters 2 and 3 of my report, I provided an executive summary and set out D's background. In chapter 4 of my report I then recorded the details of the 24 hours leading up to D's attempted suicide. I dealt with the post incident period in chapter 5. I would have obtained the information contained in my report from D's core record, F2052SH and IMR and from my interviews with the staff at HMP Pentonville. I have been informed by the Prisons and Probation Ombudsman that

D's core records, inmate medical records and F2052SH cannot now be located. I do not remember the details of these records. However, I kept a handwritten note of some of the key points in these records which is now produced and shown to me as **exhibit CD3**.

21. My findings and conclusions are set out in chapters 6 and 7 of my report. I found that on the whole, D appeared to have been well managed during his time in healthcare, as there had been frequent F2052SH conferences where his care and support were discussed. However none of these were multi-disciplinary in nature. I felt that the staff that I interviewed seemed to know him quite well. My 11 recommendations appear in chapter 8 of the report.

22. My first recommendation was that the system of referrals to both internal departments and external specialists should be reviewed. I made this recommendation because, despite the fact that D had been referred to Chaplaincy, Probation, Listeners, the Samaritans, visiting psychologists and visiting psychiatrists during F2052SH case reviews, the only person he actually saw was the visiting psychologist Dr Halsey on 18 December. After the consultation, I understand that Dr Halsey recommended that D saw a visiting psychiatrist as soon as possible. I cannot now recall if this was noted in D's IMR or F2052SH. Dr Halsey followed this recommendation up in writing on 25 January 2002.

23. D's IMR showed that he was referred to the visiting psychologist and psychiatrist on 30 November, twice on 3 December, on 4 December and on 11 December. Appointments had been made for him with Dr Akinkunmi on 5 December and on 19 December but he did not attend. I was not able to establish whether the appointments had been sent to or received by the relevant specialists. The system of referrals from prisons is not an easy one as there is always going to be a time delay between the visits of outside specialists. As far as I am aware, a priority list would have been drawn up by the clinical staff in healthcare in advance of the visiting specialist's next visit. It would have been very rare for a prison to say that it had such an acute case that it needed a psychologist or psychiatrist to attend immediately.

24. When I interviewed Dr Halsey in 2002, he explained that the system of referrals had been changed since D's attempt and that all referrals were now being

processed by a recently appointed social worker, who I understand may have been a member of the mental health in reach team or its precursor. It was he who ensured that all prisoner referrals were followed up if they were not initially seen after the first referral. However, even with this new system in place, I still felt that there was scope for an individual to fall through the system and I made a note of my reservations in paragraph 6.2.2 of my report.

25. Given D's obvious concern about his home situation and that he was missing his daughter, I was extremely surprised that Probation were not called in to assist him. However, on the day of D's attempt, I recognise that there was such a short period between him returning from his phone call and the alarm being raised that none of the staff would have had the time to discuss making any further arrangements for him to see representatives from other internal departments or visiting specialists or to note this in D's records. There was also less likely to have been as much specialist cover during this post Christmas period.

26. My next recommendation was that F2052SH case conferences in healthcare should be multi-disciplinary and the staff involved in day-to-day care of the prisoner and the prisoner himself should be present. This recommendation was in line with both local and national policy regarding F2052SH reviews and had been made in the BW and AD reports. To my mind, the key to these case conferences was that the staff who interacted with the prisoner on a regular basis should attend with the prisoner. During my investigations at HMP Pentonville, I cannot remember ever finding that a prisoner or a member of staff from outside healthcare had attended a F2052SH case conference in healthcare. It was important to the F2052SH process that the prisoner was involved and was in agreement with the action being proposed to reduce his risk of suicide or self harm.

27. I understand that it can be difficult to get staff from different disciplines in the same place at the same time when a prison is operating on reduced staffing levels. However, I have seen that it is possible for at least one non-medical member of staff to attend F2052SH reviews from my experience at HMP Holloway and HMP Wormwood Scrubs. Given that there was a Probation Officer with specific responsibility for healthcare patients and that the Chaplain would have likely been attending healthcare patients on a daily basis at HMP

Pentonville, I do not see why they could not have been called to attend case conferences in appropriate cases, even at short notice.

28. My next recommendation was also repeated in the AD report. I recommended that F2052SH forms should be returned to the landing as soon as possible after a F2052SH review. In healthcare, the F2052SH case conferences took place in the doctor's office on the R3 landing. The patient's F2052SH would be sent up for review from the R1 or R2 landing but would often not return to the landing for several hours after the meeting had finished. In paragraph 6.3.2 of my report, I explained that there was an entry in D's F2052SH on 11 December, which stated that his form had been away from the landing between 08.20 and 15.05. This meant that staff were not able to make any entries into the F2052SH at all during this period. There was also a record of a case conference for D having taken place on 20 December when he was out at court.

29. My fourth recommendation was that the pre-printed 15 minute documented watch sheets should be replaced with ad hoc watch forms with space for meaningful comments to be written whilst the observations were being made. From my interviews with the staff in healthcare at HMP Pentonville, I was satisfied that they were aware of the need for these 15 minute documented watches to be carried out at frequent but irregular intervals. However, I was concerned that the forms being used at HMP Pentonville may have encouraged agency nurses to complete their watches at regular 15 minute intervals, as this was how the form was laid out. Having said this, I did not get the impression that nurse Chikuku was carrying out predictable 15 minute observations when I interviewed her in 2002. If an inmate is really determined to self harm or to attempt suicide, they will find a way to do so, even if they are on a 15 minute irregular watch, as it can really only take a few minutes, and so could be attempted at any time after the last observation and before the next. The only way around this that I can see is to order a constant one to one observation, but this is very intrusive for the prisoner.

30. My next recommendation was that access to anti-ligature scissors should be improved and consideration should be given to issuing these to all staff who work with prisoners at risk of suicide or self-harm. I also made this recommendation in the AD report. The anti ligature scissors at HMP Pentonville were kept in a locked treatment room on the R1 landing. Although this was not far from D's cell, the scissors were not immediately located by the nurse on duty at the time of D's

attempt. Senior Officer Hayward had to explain that they were in the emergency bag. Even then, they were not handed to him or the other officers involved in trying to support and cut down D. The emergency bag was just thrown into the cell and so Senior Officer Hayward had to leave the other officers to support D temporarily whilst he went to get them out of the bag. I believe that the decision as to the issue of scissors was left to each individual prison. I am pleased to say that Prison Service practice in this area had now evolved, with the introduction of a personal issue cut down tool to all Prison Service staff who have any contact with prisoners.

31. My sixth recommendation was that new local guidance setting out who had authority to order watches should be issued to all staff at HMP Pentonville. This was more of a general recommendation made as a result of my interviews and interaction with staff at HMP Pentonville. During my interviews with the staff at HMP Pentonville it became clear to me that there was some uncertainty as to who had the authority to determine the appropriate level of observations for a patient. I do not think that this had any particular impact on D but thought it was important to raise from a learning perspective.

32. My seventh recommendation was that all serious incidents of self-harm should be reported and the prisoner's next of kin always contacted without delay where necessary. In paragraph 6.7.4 of my report, I explain that the prison did not take immediate steps to contact D's family or to report the incident to Prison Service Head Quarters, National Operation Unit, the Area Manager or the Press Office. This happened later in the evening of 27 December, when the Royal Free Hospital rang the prison to obtain the details of D's next of kin to inform them that his condition had deteriorated.

33. My next recommendation was that post incident care and post incident debriefs should be made available to all staff involved in serious incidents. This recommendation was also repeated in the AD report. Post incident care for staff is a matter of national policy and was part of HMP Pentonville's contingency plan. However, in practice, there was neither a hot de-brief directly following the incident, nor was there a critical incident de-brief which I would have expected to have taken place within 7-10 days of the incident.

34. I believe that it is only natural that the officers involved in D's resuscitation would have been distressed and traumatised. They would clearly have benefited from the support of their peers and even a very brief chat, directly after the incident on 27 December. As I said at paragraph 6.7.2 of my report, I understood that staffing was tight on 27 December and that two members of the resuscitation team had to accompany D to the Royal Free hospital before returning to HMP Pentonville to complete their evening duties. However, the simple fact is that the same officers were involved in these incidents time after time and I felt that it was really important that they be given the time and the support that they needed to help them come to terms with their experiences. The lack of follow up and post-incident care was not neglectful; it was just not normal procedure at HMP Pentonville. This issue was not unique to HMP Pentonville; in fact the position was the same in a number of prisons in the London area, and I have made this point in other death in custody reports.

35. My next recommendation related to post incident care for agency nurses. I recommended that when an agency nurse was involved in a serious incident, a senior member of healthcare staff should be on hand to offer support and inform the nurse's agency as soon as possible. I also made this recommendation in the AD report. During my interview with nurse Chikuku, she told me that she had been supported by her colleagues at HMP Pentonville on 27 December and been offered counselling to help her deal with the experience. She was also relieved from her F2052SH observations for the rest of her shift. However, she was surprised that no one from HMP Pentonville had informed her agency what had happened.

36. My tenth recommendation was really aimed at the London Area Taskforce. I recommended that the Area position regarding resuscitation training should be evaluated and consideration given to its development in consultation with the London Area Taskforce and Local Primary Care Group. At this time, resuscitation training was an issue for all London prisons and the training being provided was largely divergent. When I interviewed the discipline staff in healthcare at HMP Pentonville during my investigations, they were full of praise for Senior Officer Peter Hayward and the efforts that he had made to get a resuscitation team up and running at the prison. When I interviewed Senior Officer Hayward, I was amazed at how highly trained he was and was impressed with the work of his resuscitation teams. He wanted the model that he had

developed at HMP Pentonville to be rolled out across London, which I believe is what ultimately happened.

37. My final recommendation was that a thorough review should be conducted of the record keeping systems in healthcare at HMP Pentonville. I believe that I also made these recommendations in the AD and CM reports. I seem to remember that D's F2052SH documentation was not complete, as some of the documented 15-minute watch forms were missing. When I raised this with the staff in the healthcare centre at Pentonville, they made every effort to locate the missing forms. I seem to remember that they completely stripped the records office and searched the healthcare landings and offices to try and locate them. I was not surprised that some of the records had been mislaid, as the record keeping in the healthcare centre was chaotic at that time. The staff fully accepted that the record keeping system was not ideal and they were trying to find ways to improve it at that time.

Healthcare at HMP Pentonville

38. I found that healthcare at HMP Pentonville was far more chaotic than healthcare in other London prisons that I had seen in terms of the physical environment and the systems and procedures in place. It is difficult to compare prisons in this way as they all fulfil different roles. HMP Wandsworth may be seen as similar to HMP Pentonville in terms of throughput as it was working as a local prison, as was HMP Holloway. HMP Wandsworth had a population of between 1,500 and 1,600 prisoners, but had three vulnerable prisoner wings for long term, nationally allocated prisoner placements. At HMP Wormwood Scrubs they had a training prison and a therapeutic community so in reality, only 2 wings were operating as a local prison.

39. HMP Pentonville is one of the busiest local prisons in Europe, with over 200 movements a day and a population of 1,300 prisoners. This phenomenal rate of movement meant that the whole prison could end up in a state of flux and there were only a limited number of staff to deal with all of the movements through reception and healthcare. In 2001, I cannot recall that there was a dedicated detox unit at HMP Pentonville so the healthcare landings would have been used to accommodate those undergoing detoxification treatment for drug or alcohol misuse as well as the physically ill, the mentally ill and those at risk of suicide or

self-harm. From my experiences at HMP Pentonville, I seem to remember that finding the necessary accommodation was often challenging and trying to deliver consistent care in that kind of environment took an amazing amount of effort.

40. However, it is fair to say that healthcare was not good in any of the London prisons at that time. I was the healthcare manager at HMP Holloway between 1996 and 1998. We also had some real issues with healthcare during that period, again due to staff shortages and the standards of agency staff which we were actively trying to address.

41. I believe that healthcare at HMP Pentonville was in a worse physical environment than HMP Wormwood Scrubs for example, which had a separate purpose built hospital which was large and busy. The staff at HMP Pentonville had been delivering healthcare on a residential unit ever since their healthcare centre had been condemned in the early 1990s. HMP Pentonville was also more reliant on agency nurses than HMP Wormwood Scrubs. However, I do not think that HMP Pentonville was more reliant on agency nurses than HMP Wandsworth.

42. I felt that HMP Pentonville had a lack of quality middle managers in Healthcare during 2000/2001. This was one of the key issues in the AD investigation, where serious concerns were raised by both myself and the coroner about the conduct of a male F Grade nurse. I believe that there was a separate disciplinary investigation into his conduct as a result of the concerns raised.

43. During my investigations I would often go down to the healthcare landings and observe the officers and nurses at work with the patients. I had no doubt that the staff that I met in healthcare at HMP Pentonville were providing as good a level of service as could be provided in difficult circumstances. They knew the prisoners' backgrounds and their issues and they interacted with them and they cared for them the best they could. I never got the feeling that staff were locking doors and abandoning people.

44. I did get the impression that there were some tensions between staff in healthcare at HMP Pentonville on occasion. This was a general observation made on the basis of the interviews that I had conducted with healthcare staff at HMP Pentonville in 2001/2. I got the impression that tensions arose on the basis

that nurses would only do certain duties and that officers felt that they were having to do the nurses' jobs for them at times. For example, nurses could not unlock patients without discipline officers being present. I think that these kinds of frustrations often arise in situations where there are a mixture of roles and responsibilities and was not unique to HMP Pentonville.

Healthcare regime

45. I felt that compared to purpose built healthcare centres, which have specially designed association areas, the inmates in healthcare at HMP Pentonville in 2001/2 could not benefit from a very productive regime as they did not have a great deal of association space. The only space that they had available at that time was the R1 landing. I did not think that the patients had a lot of time out of cell. This is always difficult in healthcare as there is a limit to the number of prisoners who can be unlocked without several discipline officers being present. I understand that in 2001, Christmas Day and Boxing Day fell on a Tuesday and Wednesday. It is likely that healthcare at HMP Pentonville would have been operating on reduced staffing during this period. However, even on minimum staffing levels, I would still expect patients to go on exercise and association.

Comparative management of healthcare and care of those at risk of self-harm or suicide

46. As I have explained, there are a number of large local prisons in the London Area but none of these are a direct comparator prison for HMP Pentonville. Most of my investigations were conducted at HMP Pentonville. I also conducted a death in custody investigation into the suicide of a prisoner in the segregation unit at HMP Wandsworth and another into the suicide of a prisoner in the Vulnerable Prisoner Unit at HMP Wormwood Scrubs. I do not feel that I can helpfully compare the management of healthcare or care of those at risk of self-harm or suicide at these establishments as neither of these prisoners were in healthcare or had any real dealings with healthcare and neither had been identified as being at risk of suicide or self harm prior to their suicides.

47. Having said this, I do believe that staff at HMP Pentonville were generally very alive to issues surrounding suicide and self harm generally. In fact, as I mentioned at paragraph 6.2.2 of my report into the death in custody of Mr AD, HMP Pentonville received a 'double good' overall rating in its 2002 Prison Service

Security and Standards Audit. This was remarkable, as it was the first time that a local prison had achieved such a high level of audit compliance. Compliance with the Suicide Prevention part of this audit was deemed to be good, which was the highest mark which could be achieved in this audit.

48. It should also be borne in mind that the Prison Service as a whole has moved on a great deal since 2001 in terms of healthcare, with the assimilation into the National Health Service and the transfer of commissioning responsibility to the Primary Care Trusts.

Preventing suicide and self harm at HMP Pentonville and other prisons

49. This is a very difficult question to address, given that D's attempt was nearly 6 years ago. The Prison Service's approach to the assessment of the risk of suicide and self-harm has also changed dramatically, through the introduction of the Assessment, Care in Custody and Teamwork ('ACCT') planning system which has brought in an entirely different multi-disciplinary procedure. Learning throughout the Prison Service in the area of suicide and self-harm has also been reflected by the development and issue of new equipment such as the new cut down tool, known as the Big Fish.

50. To be honest, trying to compare the polices and practices in 2001 with those currently in place is like comparing chalk and cheese, which seems grossly unfair. As far as investigations in to deaths in custody are concerned, practice and procedure has also evolved to reflect current thinking. I was involved in a pilot for disclosing death in custody reports to the family of the deceased for their agreement. It was not an easy experience but was a further step in the evolution of the Prison Service's practice in this area. The involvement of the Prisons and Probations Ombudsman in investigating deaths in prison custody and now a near death in custody has provided an open and independent approach which always involves the family of the deceased. This has increased the professionalism with which investigations are carried out.

51. In terms of suicide prevention, I believe that the Prison Service is just beginning to address the ability of its staff to deal with the prison population. As a significant proportion of the prison population is recognised as suffering from mental illness, there is a clear need to better equip staff to deal with this issue. I am not saying

that all prison staff should be registered mental health nurses, but that further training to give staff a heightened awareness of mental illness would be helpful. It is often difficult for staff to understand the behaviours of serious or chronic self-harmers and what coping mechanisms or level of interaction should most helpfully be offered to them. This is a problem across the prison estate. I believe that the ACCT training went a long way towards improving this and that the training given to assessors and case managers is excellent, but not all Prison Service staff are trained ACCT assessors.

I believe the facts provided in this statement to be true

Signed........................

Position GOVERNOR HMP PARKHURST.

Date 29th June 2007.