

Day 3 Bundle 3 Tab 1

First Witness Statement
Her Majesty's Prison Service
Gareth Davies
4th April 2007
Exhibits GD1-GD7

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 GARETH DAVIES

I, Gareth Davies of **Charing, Kent**, WILL SAY AS FOLLOWS:

1. I was the Governing Governor of Her Majesty's Prison Pentonville ("HMP Pentonville") between June 2000 and February 2005. I retired from service in October 2006. I am afraid that I do not clearly remember D's suicide attempt on 27 December 2001 given the passage of time. I think that I was on duty on that day and remember being provided with regular updates. I remember that I was kept informed as to the efforts of our Emergency Medical Response Team ("the resuscitation team") and then on D's condition once he was transferred to hospital. It is not standard practice for Governors to attend the scene of such incidents, as they do not want to hamper the resuscitation team's efforts. I remember the clear impression at the time was that he had made a full recovery. What strikes me most about D's case is that had it not been for the resuscitation team, D would have succeeded in his attempt to take his own life.

Background and qualifications

2. I started my career in the army, where I commanded a battery. I joined the Prison Service in as Assistant Governor at HMP Pentonville in September 1980. I then became Assistant Governor of HMP Albany and then Head of Residence at Wandsworth. From there I went on to become the Staff Officer to the Area Manager for East Anglia, which was the first post of its kind. I then became the Deputy Governor of Wormwood Scrubs and went on to be the Governor of Canterbury between 1995-1997.

3. From 1997-2000 I was the Head of the Management Selection and Succession Unit where I was the Grade Manager for all Governors of Grade 3 and below. This would be the equivalent of those at Prison Service Senior Management Grade D nowadays and covered Deputy Governors of big prisons and Governors of small prisons. I was responsible for the Review of the Accelerated Promotion Scheme, which concluded that very able candidates were being recruited but far too few were successfully passing the assessment centre to enter at Governor Level, as they were not being adequately trained before the assessment.

4. I then spent 6 months working for the UN in Kosovo before returning to take up the post of Governor at HMP Pentonville in June 2000. Towards the end of this post, I went to Iraq for six months as Director of Law and Order in Basra. This would have been between December 2003 and June 2004.

Appointment and brief

5. From my recollection of events, the 1994 report by Her Majesty's Chief Inspector of Prisons ('HMCIP') contained some negative findings in relation to the hospital at HMP Pentonville. In 1994 the existing hospital building was condemned and closed down because it was riddled with asbestos and was very damp. Some low level cells were even prone to flooding in bad weather. The corridors were also too narrow to allow for the use of hospital trolleys. The government did not provide any additional funding following the 1994 HMCIP report and the condemnation of the hospital. Therefore, in order to continue providing healthcare services at HMP Pentonville, R wing was turned into a healthcare centre. I believe that HMP Pentonville should be able to provide a plan of the various R wing landings, which made up the healthcare centre in 2001.

6. The situation came to a head in 1999 when the HMCIP again produced a negative report with respect to healthcare at HMP Pentonville. The report sent a clear message that rebuilding the healthcare centre 'deemed essential five years ago' really should be made a funding priority. The Prison Service acknowledged that healthcare at HMP Pentonville needed to be sorted out and indeed this was the brief that I was given by Deputy Director General Phil Wheatley when I was asked to become Governor in 2000. In fact, my very first meeting as Governor was with the Head of Prison Health, John Boyington, regarding the healthcare centre's so called 'red light' status.

7. Prison Health used a traffic light performance monitoring system to assess the performance of healthcare centres. If a prison had 'red light' status for its' healthcare centre as opposed to amber or green, it meant that the problems faced by the healthcare centre were such that both decisive short and long-term

action was necessary to provide a service which was safe and acceptable to prisoners. The healthcare wing at HMP Pentonville was identified as a high-risk place because it was not suitable to be used as a hospital. It was designed as a galleried cellblock and not a hospital. The treatment rooms were limited to the size of cells, there were insufficient offices and no lifts. The standard of cleanliness deliverable in a Victorian cellblock fell short of what was required in a modern hospital. 'Red light' status was not uncommon and all the big local prisons like Birmingham, Wandsworth and Brixton were in a similar position at that time. I attended monthly (and later quarterly) red light meetings to discuss how to improve healthcare at HMP Pentonville even before I took up the post of Governor. I remember feeling quite challenged by the scale of the task that lay ahead of me.

8. I asked the former Governor of HMP Pentonville, Bob Duncan, what he thought needed to be done to improve healthcare at HMP Pentonville. I respected Bob Duncan's opinion, as he had been Governor of four Grade 1 prisons. Bob explained that there was a difficult population mix at HMP Pentonville, which was really a result of the catchment area. This is roughly the North East quadrant of London, so it covers the area around the A1 out as far as Hertfordshire as well as the area around the Thames and out as far as Essex. The catchment area contains five of the poorest boroughs in Great Britain, which have very high crime rates. When I became Governor, HMP Pentonville saw an average of 42,000 movements through reception a year, which had risen to a projected 48,000 by the time I finished my tour. This translated to the admission and accommodation of approximately 9,500 new prisoners a year, as not all those received were sentenced and remanded. 13% of these new prisoners had acute psychiatric needs. Such people are normally defined as requiring treatment in a secure unit.

So the population grouping which we had to deal with at HMP Pentonville was challenging.

9. It was obvious that a new healthcare centre was needed before I became Governor of HMP Pentonville but the funding had just not been made available. I understand that in its 2001 Annual Review, the Board of Visitors stated that it had been advised in 1999 that the building of a new healthcare centre had been approved. With the greatest of respect, this statement is simply not accurate. When I was asked to become Governor of HMP Pentonville, I was briefed by the then Area Manager, Adrian Smith and Phil Wheatley. If the building of a new healthcare centre had been approved at this time, they would certainly have informed me of this. I made my case to John Boyington for a new hospital at HMP Pentonville as soon as I became Governor in 2000. I made it clear that HMP Pentonville would remain on 'red light' status until a new build was provided, as the risks with the current arrangements would remain until then. It was hard to tell which parts of the Prison Service were seen as spending priorities as the Governor of each prison was always fighting to try and get funding for something. However, Birmingham had just been given the funding for a new hospital and so resources were very limited. The outcome of all this for HMP Pentonville was that we would have to demonstrate substantial improvements in healthcare before the funding would be granted.

Improvements in healthcare

10. I therefore set out to demonstrate that HMP Pentonville was worthy of a new healthcare centre and was committed to improvement. In order to achieve this I knew that I would have to make and implement some difficult and unpopular decisions. I made sure that I had a team of dedicated and motivated officers to

help me achieve this. I knew that healthcare was letting down the otherwise strong institutional performance of HMP Pentonville. Indeed there were very few suicides at the prison in comparison to other big locals, which is particularly impressive given both the nature of its population and its very high turnover. I feel that it is likely that HMP Pentonville's figure would have been lower than the rate in other comparable local prisons at that time. A table showing the number of self-inflicted deaths in local prisons is now produced and shown to me as **exhibit GD1**. I was keen to implement changes in healthcare, but did not want, in the course of these changes, to compromise the good results obtained in areas such as suicide prevention. In short, I did not want better procedures in audit but with worse outcomes in terms of the number of suicides.

11. When R wing was converted to form a healthcare centre, two of its five landings were converted into healthcare cells and offices. The wing contained two five-bed wards and approximately 60-70 healthcare cells. In the middle of the wing an office was set up on level 1, for wing administration and a nursing station was set up on level 2. The healthcare centre was run by the Senior Medical Officer ('SMO'), Dr Yisa. He was not a GP, which was common for Prison Service SMO's at that time, and I believe that he originally qualified as a paediatrician. He and his team of doctors and nurses were responsible for the medical welfare of prisoners at HMP Pentonville. This involved assessing, treating and referring patients for outside treatment if necessary and keeping an Inmate Medical Record ("IMR") and prescription sheet for each prisoner. This was a huge administrative burden and given the sheer volume of prisoners moving through the prison everyday it was sometimes difficult to keep track of medical records. This is what I meant when I referred to record keeping at HMP Pentonville as chaotic. I should imagine that this burden has been eased to some extent by the introduction of screen-based records.

12. Dr Yisa was dedicated to prisoner welfare and was completely committed to suicide prevention. He had some very good contacts in the medical community and was able to get a fair number of mentally ill patients referred to psychiatrists and psychologists. This is very hard to do as the Doctor of a big local prison, because usually no one wants to help you out. It would sometimes take a week or so to organise a referral but this was a standard waiting time in prisons at that time. Dr Yisa favoured the use of wards, as he believed that prisoners were much less likely to self-harm in this type of environment. He employed nurses to sit and watch the prisoners from behind glass all night long. I felt that that this was one of the bad institutional habits that had developed over time because no one had ever questioned it, and I agreed with the Suicide Awareness Support Unit at Prison Service Headquarters (now replaced by Safer Custody Group), who found that this type of constant watch was very invasive and had a negative impact on prisoners' wellbeing.

13. I took the view that Dr Yisa would thrive if he could focus on the clinical side of healthcare and so decided that a management change was needed. I therefore asked my Head of Residence, Gary Monaghan, to assume the role of Head of Healthcare. I gave him responsibility for the day-to-day running of the healthcare centre and the healthcare budget. This caused a great deal of tension with Dr Yisa who did not respond well to the idea that he would have to seek approval from a manager before he could make decisions regarding staffing and other management issues.

14. The idea behind this change was to get the institutional skills and discipline that were being demonstrated on the wings into the healthcare centre. By this I mean simply that the prison regime was not being followed in the healthcare centre with

regards to issues like record keeping and cleaning and that patients seemed to be languishing, as they did not have any meaningful interaction or activity in their daily routine. For example, as the healthcare centre was actually a converted wing, the bars at the end of the ward had been covered with Perspex so that there were fewer ligature points. However, on my first walk round as Governor I noticed that the area had become so dirty that there was an inch of bluebottles behind the Perspex! The regular wings were never allowed to get in to such a state, as there was a cleaning officer and a party of prisoners on each to keep them clean.

15. Given my experiences as a governor, I believe that one of the reasons that the regime was not being followed in healthcare at the time was that there would be approximately 1,000 people at HMP Pentonville in any given year who really needed secure unit treatment and most of these were being accommodated in the healthcare centre. A significant number of these prisoners were completely incapable of taking care of themselves, let alone keeping their healthcare cells clean. The strain that continually caring for the needs of these prisoners had placed on staff was apparent and had definitely had a negative impact on staff morale. It also appeared that the prison regime was not being implemented as the nursing staff did not see themselves as prison medical staff but as purely clinical staff, which had led to the development of a 'them and us culture' between prison officers and nursing staff.

16. We decided that in order to improve the situation, we needed to recruit and train prison officers specifically to work in healthcare so that they could interact more with prisoners and create a less chaotic environment. Gary Monaghan requested thirteen new members of staff for the healthcare centre. I believe that this included five discipline officers, six healthcare officers and two officer managers.

Although no additional central funding had been provided to improve healthcare at HMP Pentonville, I needed money to make the improvements we had envisaged. In order to provide the extra prison officers at an average of £23,000 per annum, I therefore had to take money out of other areas in the HMP Pentonville budget. This is standard practice for governors, who often have to 'rob Peter to pay Paul'.

17. Amongst the prison officers moved into the healthcare centre was John Attard, who was at the time acting up to Principal Officer. He swiftly became Gary Monaghan's deputy and took control of the day-to-day business of improving healthcare. The first thing that John Attard did was to issue cleaning schedules. He got a party of prisoners together to clean the healthcare cells of those who could not look after themselves twice every day. John Attard also found out that one of the prisoners was a talented artist and so encouraged him to paint some murals. He painted some high quality landscapes on to the walls of the healthcare centre, which really changed the look and feel of the place. This was all accomplished within my first three months as Governor. The healthcare officers worked hard to put a regime in place and instituted a system of light work for healthcare patients that, I seem to remember, involved them putting together cardboard jackets for files.

18. John Attard wanted the wards to become workshops and classrooms. He succeeded in reducing the number of beds in healthcare from between 60-70 to around 40, in 2001. He turned the ward into a workshop and also brought in an art therapist and a pottery instructor. I must explain that the workshop was also known as a day centre and was open whenever the art therapist or pottery tutor was available to run a class for us.

19. I believe that all of these improvements had been made by the beginning of 2001.

There would have been healthcare action plans drawn up which would have had specific implementation dates on them. I would also like to clarify my comments to the Ombudsman regarding our progress in this regard. In my transcript I said that we had made massive improvements in healthcare in 2000 but that progress stalled slightly in 2001. I did not mean that our good works in 2000 were undone in 2001, simply that we went through a period of consolidation and stocktaking, before moving forwards again. This is to be expected when dealing with a major project of this nature.

Building the new healthcare centre

20. Healthcare at HMP Pentonville was transformed thanks to these initiatives and in approximately 2001 or 2002 the Treasury agreed to provide the £7,000,000 needed for a new dedicated healthcare centre at HMP Pentonville. Martin Narey, the then Director General of Prisons, and the then Prisons Minister, Paul Boateng, were taken round the improved healthcare wing to witness the improvements we had made. The outcome of all this was that substantial improvements had been evidenced and we had definitely earned the money for the new healthcare centre.

21. However, the fight to secure funding was not the end of the matter. As HMP Pentonville was built in 1842, it has the status of a Grade 2 listed building. This means that alterations can only be carried out with the prior approval of English Heritage. They were being particularly difficult as the old hospital at HMP Pentonville had the earliest known isolation cell, which had been used for prisoners with tuberculosis, but it was flooded and riddled with asbestos. In order to move the project forward, I attended meetings with English Heritage at their

offices in Saville Row. When I informed Paul Boateng that we were having problems, he offered to take up the matter with Chris Smith, who was not only the head of English Heritage, but was also the MP for Islington at the time. The people from English Heritage ended up taking photographs of absolutely everything in the old hospital but eventually they agreed to let us tear it down and build a new healthcare centre.

22. The Prison Service Works Department may still have records of when the actual demolition work started but I am not sure about this given the passage of time. However, it was not a simple process as a lot of enabling works needed to be carried out before any of the building could be started. First we needed to open a new gate through which we could route prisoners in. Then the contractors had to build a secure compound around the potential building site using corrugated iron and razor wire. Within the site there was also the problem of avoiding the disturbance of graves, which is common in prisons of this age. This was a stressful time for me as I was responsible for everything that was happening on the site until it had been secured, right down to the health and safety of the building contractors. I am afraid that I cannot remember exactly when this was but I think that I would have recorded the exact dates in my Governor's Journal. I am not certain if the Governor's Journal is stored in the National Archives or in the Muniments Room at HMP Pentonville.

Policy changes in healthcare

23. At the same time as the building works were being carried out, HMP Pentonville was continuing to implement prison procedures in healthcare such as the F2052SH reviews and was preparing to hand responsibility for healthcare over to the Camden and Islington Primary Care Trust ('PCT'). The scope and nature of

the work needed to implement the practical aspects of aligning Prison Health with NHS policy was vast. Amongst the measures we had to implement was the requirement that all prison doctors must be either qualified or accredited as general practitioners. Not many, if any, of the SMOs in the London Area were so accredited and the period for qualification was about two years. Therefore we needed to plan the business continuity so that we could continue to provide the necessary medical supervision in prisons whilst the SMOs were away training. I chaired a group from the London Area Prisons along with the London Regional Health Authority to discuss how best to achieve this.

24. When the NHS took control of healthcare at HMP Pentonville in 2003/4 they also took control of healthcare budgets. This meant that all the Prison Service's funding for healthcare went straight to the NHS. The NHS would then give these funds back to HMP Pentonville for them to staff and equip their healthcare centre. To be honest, the only real difference to HMP Pentonville was that the funding and procedure then came from the NHS rather than the Prison Service.

Staffing

25. I struggled with staff recruitment throughout my time as governor of HMP Pentonville. I understand that this was a common problem in the Prison Service at that time. I seem to remember that the situation was particularly bad in the London area in 2002, when both the Metropolitan Police and London Transport launched large recruitment drives. I cannot remember exact figures now but believe that I may have been around fifty prison officers short of a full complement at certain points during 2001 and 2002. The Human Resources department at HMP Pentonville may be able to provide more detailed information about staffing

levels but I am not certain if information relating to years 2001 and 2002 are still retained.

26. Staffing prisons is an exercise that is largely dictated by the number of uniformed staff required to provide the prison regime at the weekend. Owing to the alternate weekend working of the unified grades of staff, the weekday staffing is normally twice that of the levels at the weekend. Christmas holidays, more often than not, do not fall on the weekend, and when they do, extra Bank Holidays normally accrue. This means that the holiday routines, which are essentially the same as weekend routines, are staffed from a profile designed for the much higher activity level of a weekday. Therefore, It is not difficult for a manager to provide the full staffing levels required for the stipulated regime. We did not usually have problems getting staff to work on weekends and many were prepared to work overtime as they were able to take time off in lieu to make up for any extra hours worked.

27. We also found it difficult to recruit and retain permanent nursing staff. I am not sure whether this was a London or nationwide problem at the time. The Prison Service cannot offer the pay and conditions which would attract top quality nursing staff and so it is a sad reality that some nurses working in prison health have ended up there because they have not been able to find work elsewhere. When I first arrived at HMP Pentonville, I discovered that it was difficult to recruit and retain good nurses in the healthcare centre because the atmosphere was so chaotic. This chaos resulted from the physical set up of a healthcare centre in a converted wing, the challenging healthcare population and the lack of stimulation for healthcare patients. I believe that the SMO did try to compensate by hiring a large number of agency nurses. However, this did not solve the problem as even

experienced agency nurses were not always familiar with the local prison environment and did not understand the prison routine.

28. One of the first changes that we implemented was to give John Attard responsibility for management decisions in healthcare, leaving the SMO free to concentrate on clinical issues. By 2001 he would have been responsible for staffing in the healthcare centre, including the hiring of agency nurses. Peter Hayward, the pioneer of the Emergency Medical Response Team ("the resuscitation team") was probably also involved. John Attard did eventually manage to improve the staffing in healthcare by hiring a brilliant matron, a Grade I nurse, called Kay George. I believe that she was with us for a couple of years. Kay managed to establish some control in the centre and created order out of the chaos. Her influence was very positive.

29. During my tape-recorded interview with the Prisons and Probations Ombudsman, I said that I had dismissed three nurses in my time at HMP Pentonville. I would like to clarify this statement and explain that these were not decisions I took lightly. I dismissed the first in 2003 for lying about whether he had returned shoelaces to a prisoner who then used them to hang himself. A further two nurses were dismissed in 2005 for failing to take the proper resuscitative action after a prisoner had suffered a heart attack. All these decisions were made as a result of formal disciplinary investigations and hearings. I must also explain that I moved the Principal Healthcare Officer from his healthcare post when I became Governor in 2000, as I was aware of some serious performance deficiencies on his part. He had allegedly been having an affair with the senior nurse and I suspected that he had been dishonest with respect to paying her for overtime. He later resigned from the Prison Service altogether.

Recruitment, Induction and Professional training

30. I felt that prison officer staff induction courses were very good. In fact, new prison officers were very well informed and competent as a result. There had been three different training courses since the 1980s. The first was New Entrant Prison Officer Training, known as NEPOT and the second was Prison Officer Initial Training known as POINT and the most recent was Prison Officer Entry Level Training, known as POELT. All officers had to go through a vetting process. Then they would spend time with a training officer in a prison wearing civilian clothing. After this they would be sent on a sandwich course, which took place in Wakefield or Newbold Revel (and in more recent years at Feltham). The training officer would make sure that the prison officer was competent in all areas of duty before passing them as fit to commence duties.
31. Each prison officer would have a line manager with whom he would discuss his training and development needs. An individual development programme would then be drawn up each year and a supervisor would oversee this. I believe that this system was in operation in 2001. In addition to this, every prison officer would have access to counselling to help him deal with the difficult situations he might have to face in the course of his work. This would either be informal, or organised via the care team at HMP Pentonville.
32. Ongoing professional training was mandatory in the areas of suicide awareness and control and restraint. These two courses were top of our list of priorities and were carried out by all members of staff. However, there was a long list of other courses deemed to be mandatory at that time. A copy of PSI 15/2001, which contains a list of the training requirements for 2001, is now produced and shown

to me as **exhibit GD2**. The large number of mandatory courses made it very difficult to ensure that all staff members attended the necessary training whilst still maintaining an adequate complement of staff at any one time. A prison officer is conditioned to a thirty-nine hour week, but only 32.8 of these hours are 'effective'. The non-effective hours are taken up with sick, leave and training. The proportion of hours allowed for training was much lower than needed to meet the requirement for mandatory training. So there was always a tension between fulfilling training requirements, staffing levels and funding. However, I must stress that a lot of informal training was provided on the job. For example, if, say, the Deputy Governor discovered a prison officer writing insufficient comments on a form, he would be taken aside and told what he should be doing there and then. Professional supervision and support whilst on the job was always a part of continuing development for all officers. We also recognised the importance of training based on lessons learned and relied on a system of post incident debriefs to collect this information. The debrief would usually take place within between a week and a month from the date of the incident in order to give us enough time to assess the impact and knock on effect of an incident.

33. As far as nurses were concerned, they received jail craft training. I believe that this training subsequently became known as the "Prison Awareness course". This training was basically to teach them about working within an institution. Nurses were also able to have further formal prison officer training to allow them to become hospital officers. Jail craft training was not just for nurses but also for any outside professionals recruited such as teachers and probation officers and even governors. This training was essential to help new recruits understand the prison environment, and the challenges posed by that environment. It is important that certain behaviours are picked up in prison that would not necessarily be problematic in the outside world. Let us take for example a man who requests a

copy of Country Life. This would not normally arouse anyone's suspicions. However, if this man were a convicted burglar then this could be a serious matter as it might indicate that he is planning a job from the inside.

34. F2052SH training was given to every member of staff. This training was really about teaching staff about how to fill in the self-harm/at risk form ('F2052SH') in a meaningful way and counsel the at risk prisoner. By 2001, the landing officer would have been writing in an open form twice every day and the duty Governor would have been checking all open forms daily. There was a real drive to make the forms meaningful at this time, and if a comment such as 'appears to be asleep' were made, the duty Governor would immediately pick up on it. We reached a stage where the comments were generally good and relevant. However, I was forced to sack a prison officer in 2003 for making facetious comments in a F2052SH. When I did so I got the definite impression that the staff agreed with my decision and so took this as evidence that some cultural change had been achieved.

Detoxification Policy and practice

35. The detoxification ('detox') unit at HMP Pentonville was in C wing. It was on the second floor and sometimes on the third floor as well. Prisoners requiring detox would have gone straight from reception to the detox unit. There was a detox specialist at HMP Pentonville around the time that D was there. I cannot remember his full name now but know that he was an overseas-qualified doctor who left the Prison Service to re-qualify in the UK. I don't fully recall HMP Pentonville's detox practices in 2000/2001 but I think they were based on a mixture of palliative care and methadone. I cannot be certain given the passage of time. I do however recall that we were doing quite well in terms of detoxing

prisoners, as the number of prisoners being detoxed was high. We were detoxing around 3,000 prisoners a year, which I believe may have been more than the National Health Service was doing in the whole of the south of England at the time. During my time at HMP Pentonville Prison Service detox policies changed significantly to meet the accepted practice in the NHS.

36. There is a link between detox and depression as when prisoners come off drugs, they are confronted with the problems in their lives. We were trying to do our best for substance misusers at HMP Pentonville but we could not get any additional funding to do more than we already were. I, for example, became very keen on sports therapy after watching a documentary about the physical capacity of recovering substance misusers. They used a FITECH machine to measure the heart rate as well as the lung function and capacity of those recovering from substance misuse so that they could monitor the improvements in their physical fitness after coming off drugs. This was a good way of helping prisoners increase their sense of self worth because it gave them a means of measuring their improving fitness and reduced the likelihood of their becoming depressed. Unfortunately, HMP Pentonville could not obtain funding for the necessary equipment and so I was forced to give up on the idea.

Suicide awareness and prevention

37. I always considered that keeping the suicide rate low and minimizing the number of suicide attempts at HMP Pentonville was my top priority. It is mind numbingly shocking to have someone for whom you are responsible kill themselves and so we would always take self-harm and suicide attempts very seriously.

38. All prison officers were given basic suicide awareness and prevention training which would be updated at regular intervals. The training included how to support a prisoner found hanging and how to cut them down using special anti -ligature scissors. These were an important piece of kit as they allowed a prison officer to cut down a prisoner without cutting them. These scissors had to be kept under lock and key so that they did not fall into the hands of prisoners. I understand that these have now been replaced by a long awaited knife, known as the big fish because of its shape. The idea behind these knives is that the blade is concealed so in principle it could not be used as a weapon if it fell into the hands of a prisoner. This means that every prison officer will be able to carry one. PSI 32/2006 regarding Personal Issue Cut-Down Tools is now produced and shown to me as **exhibit GD3**.

39. The key difficulties in terms of suicide prevention are that those who actually go on to kill themselves are not usually those who display outward signs and that a person who self harms in one way may unexpectedly switch methods and make a successful attempt without any warning or signal. Some of those who are put on to F2052SH forms (self harm at risk forms) are often looking for attention or crying out for help and assistance. When I became governor of HMP Pentonville some of the nursing staff would say that prisoners were just self-harming as a cry for help, to which I would retort 'well why is he not getting any then?' I have always taken the view that the vulnerable need attention. The difficulty within the prison environment is that you do not always get the same clues that you do in the outside world. I believe that this is because the prison environment is very intense and often gives rise to challenging behaviour, which masks an individual's true intent.

40. Once on a F2052SH form, a prisoner is regularly supervised. Form F2052SH is now produced and shown to me as **exhibit GD4**. The form shows that the F2052SH procedure is a continuing one. The form is used during each shift and the idea is basically to watch out for the prisoner at all times. The form is completed to show what a prisoner has talked about and if a prisoner were not responding then this would be noted in the observation book and on the F2052SH and then passed on through the shifts. The form stays with the prisoner at all times, except when it is needed for a case review. However, as the case reviews usually took place on the wings, the forms were never far from the prisoners.

41. The aim of the F2052SH review was to monitor the prisoner's welfare and state of mind. It was difficult to draw up more detailed care plans than this in big locals like HMP Pentonville, as you would not be able to say with any certainty how long a prisoner would be with you. However, prisoners will still commit suicide if they are really determined to do so, even if they are being watched. You cannot place every at risk prisoner on a constant watch. Constant watches have problems of their own in terms of being a complete intrusion into the prisoner's life and this itself can be very depressing for the prisoner. Therefore an informed judgement is needed in each case and this rests on professional knowledge, expertise and experience.

42. 'Suicide is Everyone's Concern' was a thematic review carried out by the HMCIP in May 1999. The review stated that the Prison Service strategy in place at the time 'Caring for the Suicidal in Custody' was well conceived but did not pay sufficient attention to those in local prisons. The report stated that this was due to the sheer volume of potentially suicidal prisoners being held in local prisons. Chapter six of the review makes recommendations as to local prisons, which

focus on training, risk assessments, and communication between healthcare staff and officers. Responses to thematic reviews usually came from Headquarters rather than from individual prisons. I understand that Safer Custody Group sent a safer custody programme out to all Governors as part of the response to the thematic review. I am afraid that I do not remember what this involved so I could not say with any certainty what action was taken to specifically implement the recommendations in this report. However, it was clear to me as a Governor that the issue of suicide prevention was treated extremely seriously by all levels of management and staff. As far as we at HMP Pentonville were concerned, it really reflected the changes that we had been making in healthcare and training generally from 2000 onwards. The review did not really tell us anything we did not already know and which had not been highlighted in our own two day seminar on suicide prevention in early 2001. This was an area-funded training event attended by members of Safer Custody Group and other London Area establishments.

43. I remember feeling quite irked that the Board of Visitors and HMCIP had been critical of HMP Pentonville's suicide prevention efforts. I felt that this criticism was unfair as the F2052SH procedures were still in the process of bedding in at that time. Their criticism focused on the delays in carrying out three-day reviews and not having a large enough team conduct each review. I found this to be totally unrealistic. F2052SHs were an enormous administrative burden in a big local prison like HMP Pentonville particularly as regards the three-day review. These reviews were supposed to be multi-disciplinary, involving representatives from areas such as probation and chaplaincy as well as doctors and officers. It was also recommended that the prisoner attend where possible. It was virtually impossible to do this for every prisoner on an open F2052SH given the large number of open forms.

44. In 2001, the so-called 'special cells' AS1 and AS2 were still being used at HMP Pentonville. These were reduced ligature cells, which were sometimes called strip cells because of their sparse conditions. A healthcare patient who was continually self-harming would be an example of the type of prisoner who might have been put in to a special cell for short term monitoring. During my interview with the Prisons and Probations Ombudsman, I likened the special cells to crutches. I was trying to explain that they were used as a way of mitigating stress upon the custodian as they were a crude way of ensuring that a patient could not self-harm. However, I was not a fan of the special cells, as I believed that by putting a prisoner into strip conditions, you were merely dealing with the symptoms and not the cause of the prisoner's problem. These cells are no longer used as prison service policy in this area has evolved concerning those at risk of suicide or self-harm.

45. The idea of setting up an Emergency Medical Response Team at HMP Pentonville came from Peter Hayward. This was not specifically intended to prevent the number of suicides but was a useful tool none the less. I was very enthusiastic about the idea, having seen something similar in action in US prisons where their main problem was with geriatric prisoners. Peter Hayward formed a team in HMP Pentonville in about 2000/2001 and prior to that trained up all members of staff to be able to carry out paramedic type tasks and perform CPR. I was very impressed with the Emergency Medical Response Team and remember feeling proud when outside paramedics praised the Emergency Medical Response Team. Indeed, I seem to remember that they commented on several occasions that they could not have done any better themselves. Peter Hayward worked up a proposal with John Attard and myself for the Emergency Medical Response Team to be used by all prisons. I believe that the initiative was

very sought after and was finally adopted by the whole London area after I left HMP Pentonville.

Communication of risk

46. I believe that the communication of information regarding the welfare of prisoners between prisons and escort staff was greatly improved by the introduction of the Prisoner Escort Record ('PER') in the early 1990's. PSO1025 regarding the Prisoner Escort Record is now produced and shown to me as **exhibit GD5**. I think that this system was first introduced when private firms began escorting prisoners. The PER recorded everything that happened to a prisoner and would cover a prisoner's actions or words. It would be the first document to be looked at upon reception. The PER forms were opened by the escort staff at court and may even have been filled in by the dock staff. The escort staff would record things like what a prisoner had said, how they had behaved, even whether they had stopped for a comfort break on the way to the prison. I am quite certain that if a prisoner had self-harmed at court, then the court staff would have opened a form F2052SH there and then handed the open F2052SH to the escort staff together with the PER. On arrival at the prison, the escort staff would hand over the F2052SH and the PER and they would usually explain to the reception staff what had happened.

Reception and Induction

47. Logistically, the hardest part of the prison process was the reception and induction of prisoners because of the sheer volume of people being moved around at any one time. Over 100 prisoners were coming in and going out every day either for first reception, court appearances or medical appointments. When a newly convicted prisoner arrived, the first thing that would happen was that the

prisoner would have a shower and then swap his civilian clothing for a prison uniform. The prisoner's civilian clothing would then be laundered and stored and his property accounted for.

48. When I first became Governor of HMP Pentonville, the system in place was that all prisoners would be seen by a doctor on arrival and that the doctor would check for any indications that a prisoner was self-harming. Over time, this gradually became the role of nurses which was much more efficient. I believe that this change would have taken place in around 2003. The reception process is never going to be fail safe as a lot turns on the accuracy of the information prisoners give to the nursing staff. I became very interested in trying to improve the quality of these initial evaluations, and started using a form, which I think had been piloted by HMP Pentonville's comparator prison, Leeds. The idea was to give each prisoner a structured interview on reception and present them with basic questions for example; do you have anywhere to live? Are you an addict? Each question in the interview had a tick box next to it to note the prisoner's response. There was then a further column for the interviewer to comment. So for example if when asked if he was an addict a prisoner said no but he nevertheless presented with signs of addiction, the interviewer could note this on the form. The idea was the greater the number of ticks on the form, the greater the risk was that the prisoner would self-harm. Unfortunately, the form was seen by some to have too many positive indicators on it, with the net result that most prisoners were deemed to be at risk of self-harm. Once this system had been put in place at HMP Pentonville, we were instructed to stop using it because of this over reporting issue.

49. After the initial reception came the prison induction. It took several attempts to get this up and running at HMP Pentonville before it was successful. The problems

encountered were mainly as a result of not having the proper areas in the prison in order to set up an efficient process. Instigating change can be problematic in big old Victorian buildings as there is often a reluctance to change a way of working that has been in place over a period of many years. For example, when I arrived at HMP Pentonville I found that the reception area was on the first floor of D wing. This is a semi-basement floor on the wing to the furthest east of the prison. I simply could not understand why prisoners were being sent there on arrival because all the new prisoners were being put on A wing, which is the most westerly. When I asked about this practice, I was told that the reception had originally been in A wing but that it was moved to D wing when A wing temporarily closed for refurbishment. Even though this was only a temporary measure, the reception area was never moved back. It took me a great deal of effort to get the reception moved back to A wing and I should imagine that the move took place during 2003.

50. PSO 0550 on Prisoner Induction is now produced and shown to me as **exhibit GD6**. Prison Service guidance on induction procedures has never been overly prescriptive. The key aim was that the prisoner was calm and non-aggressive and was treated decently. Above and beyond this, what happened on induction was largely left up to the individual prisons and each developed their own local policy. The standards of induction at HMP Pentonville were audited. However, our audits would frequently show that our induction programme did not fit the needs of our new arrivals. We concluded that this was due to the mix of prisoners in the catchment area. I believe that the difficulty with induction is that in an ideal world, the process should really be tailored to each individual prisoner. I wanted to be ground breaking in this respect and had set up a small-scale system of criminogenic interviews in either 2001 or 2002 for new prisoners. The idea behind these interviews was to establish which factors in a prisoner's life had lead them

to offend. Once these factors had been established, they could be addressed holistically, making rehabilitation more likely. For example, it was no use fixing a prisoner's drug problem if you were not also addressing the fact that he had nowhere to live at the same time.

51. One of the key improvements that we made to the induction process during my time as Governor of HMP Pentonville was in the area of providing information to prisoners. We pioneered a touch screen information service at HMP Pentonville as I felt that prisoners were not really taking all the necessary information on board during their initial reception. We stored all the necessary information about daily life at HMP Pentonville on a touch screen computer so that prisoners could either read or listen to information in a choice of six languages at their leisure rather than being bombarded with lots of information on reception. This was up and running at HMP Pentonville when I left in 2005.

Use and effectiveness of F2052SH

52. The Suicide Prevention Committee has long been a permanent fixture at HMP Pentonville. I think that it was already up and running when I became Governor in 2000. The committee met once a month to review the use of F2052SH's. At HMP Pentonville the Duty Governor checked all open F2052SH forms daily until this became the role of the Suicide Prevention Co-ordinator in early 2002. Once they were satisfied that the forms were being used fully and correctly they started to do random checks instead of daily checks.

53. From my recollection of the 2001 Annual Review, the Board of Visitors stated that HMP Pentonville had appointed a full time Suicide Prevention Co-ordinator early in 2002. His role was to improve F2052SH practices. It was not, as stated in the

HMCIP 2002 report, to begin to develop a first night centre. He provided monthly updates to the Suicide Prevention Committee.

54. The Suicide Prevention Committee took a broad view of the processes. If they thought that a prisoner was self-harming a lot then I seem to recall that they would order a specific multi-disciplinary case conference involving the Governor, Deputy Governor, Head of Healthcare, Senior Medical Officer and Wing Governor. The committee would also track the number of incidents of self-harm there had been, how many near misses, where and when these incidents occurred and how many times the resuscitation team had been called. So in this respect the committee would pick up on any increase in the number of vulnerable prisoners at HMP Pentonville and any areas requiring special consideration. I have the distinct impression that when the touch screen information system was put in to operation, the number of prisoners on F2052SH halved, but I cannot recall where I got this impression.

55. The use and effectiveness of F2052SH was audited internally as well as by the Standards Audit Unit, the Prison Service audit team from Headquarters. We would frequently carry out self-audits and set up a special unit at HMP Pentonville for this purpose. The internal audit team would use audit baselines set by Headquarters. These were really the standards that you would expect to see on the ground in order to be fully implementing a Prison Service Order or Instruction. Part of this self-audit related specifically to suicide and self harm. There were nine areas for improvement identified by the self-audit unit. I would use these audit reports as a way of finding out what was really going on on the ground. Once I knew which areas the self-audit team had identified as weak, I was able to focus on improving these areas before the external audit took place. This process proved to be very successful as HMP Pentonville was shown to be

very good on F2052SH practice and procedure and received a 'double good' in its 2001 and 2003 Prison Service Audits. A 'double good' meant that both the regime standards and security at HMP Pentonville had been assessed as good. Copies of these audit reports may be on file at Prison Service Headquarters, but I am not sure.

Recommendations in Draper report

56. I have known Carole Draper for many years, as we were Assistant Governors together at HMP Pentonville in the 1980's. I have the utmost respect for Carole Draper and she definitely knows her way around the big local prisons. I appreciate that she was doing her job when she put this report together. I really felt that that the tone of her report was overly negative. I am a strong believer in judging on outcomes rather than simple adherence to procedures. However, I think it is fair to say that on the whole I welcomed her report (as I did any audit), that is, as an effective means of finding out what is happening two or three levels below of my immediate span of control.

57. Action plans were an integral part of HMP Pentonville's continual self-audit and development and a way of evaluating the progress of new initiatives. I was involved in action planning, as I would have final say on what was to go in to a plan. However, the formulation of action plans mostly fell to my Deputy Governor, Ruth Kringle. I believe that action plans were drawn up in response to the recommendations made in the Draper Report and a copy of an action plan is now produced and shown to me as **exhibit GD7**. This action plan shows a number of areas of required action and sets out details of compliance. I believe that the deadline for implementation of this report was August 2002. This action plan was implemented alongside plans resulting from internal audits and HMCIP reports.

I believe the facts provided in this statement to be true

Signed... *Gareth Muir*

Position... *Retired Governor HMIP Reubenville*

Date... *03 Apr 07*

**First Witness Statement
Her Majesty's Prison Service
Gareth Davies
4 April 2007
Exhibits GD1-GD7**

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**

INDEX OF EXHIBITS TO WITNESS STATEMENT OF GARETH DAVIES

Tab	Exhibit	Description
1	GD1	Table of Self Inflicted Deaths at Local Prisons 1996-2007
2	GD2	Prison Service Instruction 15/2001 Mandatory Training 2001-2002
3	GD3	Prison Service Instruction 32/2006 Personal Issue Cut-Down Tools Issued November 2006
4	GD4	F2052SH Self Harm at Risk Form, undated
5	GD5	Prison Service Order 1025 Communicating Information About Risks on Escort or Transfer-The Prisoner Escort Record Issued September 2000
6	GD6	Prison Service Order 0550 Prisoner Induction Issued August 2000
7	GD7	Action Plan Arising from the Attempted Suicide of D 27 December 2001, undated