

INVESTIGATION INTO THE NEAR DEATH IN CUSTODY OF 'D' ON 27  
DECEMBER 2001

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WITNESS STATEMENT OF JOHN ATTARD

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I, John Attard of *Her Majesty's Prison Pentonville, Caledonian Road N7 8TT*,  
WILL SAY AS FOLLOWS:

1. I was the Healthcare Temporary Principal Officer at Her Majesty's Prison Pentonville ('HMP Pentonville') from September 2000 to March 2002. I do not remember D and was not present when he attempted suicide on 27 December 2001. I am aware of the Draper Report as well as the terms of the current investigation. I am happy to assist the Prisons and Probation Ombudsman in his investigations wherever possible. I was not interviewed for the Draper report. My recollection of events is not clear given that it is nearly six years after D's attempted suicide. An extract from the Healthcare Observation Book for 2001 is now produced and shown to me as **exhibit JA1**. The Observation Book shows that I was duty Governor in healthcare on 13 December 2001 when D made his first attempt. I do not remember this incident but am satisfied with the comments entered in the Observation Book.

**Background and qualifications**

2. I began my career in the Royal Navy in 1979 where I started as a Stores Accountant and then went on to become a Ship's Diver. I left the Navy in 1985 and went to college. I joined the Prison Service on 5 May 1987 as a Prison Officer at HMP Pentonville. In 1989 I qualified as a Physical Education Instructor

for prisoners and staff at HMP Pentonville before taking a brief career break, during which time I studied for a law degree. I returned to HMP Pentonville in 1995 as a Prison Officer. I was promoted to Senior Officer and then to Principal Officer on D wing before becoming Principal Officer on C wing. I became the Temporary Principal Officer in healthcare in September 2000. I was substantively promoted to Principal Officer and then temporarily promoted to Governor Grade 5 (now known as Prison Service Manager Grade F) in healthcare in the same month. In January 2002 I became temporary Governor Grade 5 on A wing. During this period I was also Head of Prisoner Development. In March 2003 I went back to the healthcare centre as Head of Healthcare at Governor Grade 4 (now known as Prison Service Manager Grade E). I took up my current post, as Head of Human Resources in September 2005. I am currently responsible for human resources, training and litigation for the whole of HMP Pentonville.

### **Problems in healthcare**

3. I believe that Prison health is a difficult balancing act, which tries to reconcile two very different aims: clinical care and custody. The healthcare centre at HMP Pentonville is not like a community hospital. Both clinical staff and prison officers have to exercise careful judgement and expertise. Managing prisoners in the prison healthcare environment is challenging as prisoners can present with a wide variety of mental and physical afflictions.
4. The 1999 Her Majesty's Chief Inspector of Prisons ('HMCIP') inspection went reasonably well for HMP Pentonville as a whole but healthcare received a very bad report. After this negative report was released, it was believed that the Prison Service would threaten to put the whole prison out to tender, as they had done with HMP Brixton.
5. Between 1994-2004, the healthcare centre at HMP Pentonville was a converted wing, which contained an eight-bed ward, two five-bed wards and single cells; which provided approximately 60-70 healthcare places in total. In 2000, the Senior Medical Officer, Dr Yisa, was running the centre through a hierarchical structure. I believe that the basic problems with healthcare at HMP Pentonville at that time stemmed from the lack of purposeful activity for patients and the failure to actively manage issues such as staff conduct and performance.

## Appointment and brief

6. In 2000 Gary Monaghan was the Head of Residence at HMP Pentonville. The Governor, Gareth Davies, asked Gary Monaghan to take responsibility for healthcare too, with a view to improving its performance. At this time I was a temporary Principal Officer on C wing. Gary Monaghan asked me if I would come and join his healthcare team and assume day-to-day responsibility for the running of the healthcare centre. I considered the offer carefully because healthcare was in such a poor state and so I knew that it was not a job to be undertaken lightly. I decided that I would take on this role and would specifically focus on the management of conduct, performance and attendance related issues as well as regime and cleanliness. Obviously clinical care decisions remained with the doctors, nurses and healthcare officers as I was not qualified in this respect.
7. Given this brief, it was clear that my arrival in the healthcare centre in September 2000 was going to create some tension. My office was a converted cell, as were all of the offices at that time. The room I moved in to had been used to store a few sets of medical records and was not even connected to the electricity supply. It was clear to me that my presence in the healthcare centre was not really appreciated but I expected this. The Principal Healthcare Officer had been avoiding me since I arrived, so I went to discuss the situation with him and to clarify that I was simply there to manage and would not have any involvement on the clinical side. The Principal Healthcare Officer was very unhappy about these changes, particularly as he would not have control over the healthcare budget and would have to come to me every time he wanted to hire an agency nurse.
8. Some of the other staff in the healthcare centre were also unhappy with the management changes being made. I was even told about a nurse who was allegedly threatened by a former senior F Grade nurse for co-operating with management to bring about changes in healthcare. It was alleged that some of the staff would arrange for a prisoner to assault her if she continued to co-operate with management. Although I had received this information third hand, I decided that I needed to take a firm line in view of the seriousness of the allegation. I went to the nurse who had allegedly received these threats and tried to establish their veracity. She would not tell me who had threatened her and said that she did not want to take the matter to the police. I followed this up by calling a meeting of the nursing staff. I explained that making threats to other members of staff was totally

unacceptable and that if I ever heard of any further threats or acts of violence I would launch a full scale investigation and dismiss those responsible. This really shocked the nurses and definitely had the desired effect. Some of the nurses came up to me after the meeting and expressed their shock and support for the clear line I had taken. Nothing more came of this, but the incident is memorable, not only for its severity, but also because it represented a turning point in my relationship with the nursing staff.

9. Above and beyond this resistance to change, I also felt that some of the healthcare staff were just getting by and doing the minimum that they needed to do to provide medical care to the inmates. Most of the problems that I identified stemmed from the fact that some of the clinical staff refused to see themselves as part of the fabric of the prison. They did not interact with prisoners and some even refused to get involved with the basic regime in matters such as cleaning. For example, I once asked a nurse to get a pair of shoes for a prisoner who was walking round the healthcare centre bare foot. He told me that it was not his job to fetch shoes! In the end Governor Davies discussed these issues with the Senior Medical Officer ('SMO') and made it clear that I had his backing in implementing any changes I deemed necessary to improve healthcare at HMP Pentonville and that he expected the full co-operation of the clinical staff.

#### **Improvements in healthcare**

10. As soon as I arrived in healthcare I drafted a healthcare action plan, which is now produced and shown to me as **exhibit JA2**. One of the first tasks undertaken in September and October 2000 was to deep clean the healthcare wing. Principal Officer Dowling, a former colleague of mine from C wing took responsibility for this. The healthcare centre was completely stripped and cleaned thoroughly. This included taking Perspex sheets off the bars and removing fixtures and fittings. The cleaning took place full time over a number of weeks. We put in new lighting and repainted the wing with bright lively colours and murals. The task took about three weeks but healthcare became a completely different place as a result. I made sure that a party of prisoners would regularly clean the healthcare centre from this point onwards and would also clean the cells of those who were too unwell to look after themselves twice daily. I even drew up 'area cleaned' hygiene certificates to be signed by the officers at the end of each cleaning round.

11. Once we had given the healthcare wing a facelift, I started to look closely at staffing and resource management issues. The hierarchy of staff in prison health involved a long chain of command. At the lowest level the Officers/E Grade nurses reported to Senior Officers/F Grade nurses who in turn reported to the Healthcare Principal Officer /G Grade nurse-manager. They in turn reported to the Governor Grade 5 (now Prison Service Manager Grade F). Medical Officers would report to the Senior Medical Officer, who was formerly seen as being on a par with the Chaplain or the Governor. By the year 2000, Prison health was beginning to assimilate itself with accepted practices in the National Health Service ('NHS'). Part of this assimilation resulted in a change in Prison healthcare policy which recognised that an SMO was not necessarily best placed to be Head of Healthcare and that dedicated managers were often able to make more efficient use of the available resources.
  
12. After I had assumed responsibility for the day to day running of healthcare, I examined how the healthcare budget was being spent. It quickly became clear to me that there were not enough checks and balances in place to ensure that HMP Pentonville was making the most efficient use of its healthcare budget. In fact, I discovered that the healthcare budget had been massively exceeded for the year 1999/2000. For example, I was shocked to learn that HMP Pentonville was spending approximately £360,000 a year on agency staff at this time. When I looked in to the reasons for this, I was told that most of this money was being spent hiring agency nurses to carry out constant watches for prisoners at risk of self harm. These were a great drain on resources, as we simply did not have enough staff to carry out all of the necessary watches ourselves. I discovered that not only were we paying agency nurses to do this but also that we were using the specialist, and therefore more expensive, Registered Mental Nurses rather than Registered General Nurses to carry out watches. This seemed heavy handed as the key skills needed were simply the ability to watch the prisoner, interact with the prisoner and to raise the alarm in case of an incident. I arranged for constant watches to be carried out by Healthcare Assistants, who were more than capable of observing prisoners, interacting with them, and raising the alarm, and who were significantly cheaper to employ than Registered Mental Nurses. In order to further reduce the budget overspend, Gary Monaghan produced a mechanism for ensuring that a monthly spending cap was adhered to. This meant that the

manager responsible for arranging agency nurses and overtime was required to seek prior written authority either from Gary Monaghan or myself.

13. I felt that this system of watches was unnecessarily expensive and inefficient. It seemed like this had become established practice in healthcare simply because no one had questioned the way that it was done. It seemed that the medical staff were not being pro-active in the management of their patients and were simply putting prisoners on constant watch without taking a long-term view of the prisoner's overall care and management. The process of continually watching someone can be very invasive and can, I believe, actually make a prisoner feel more vulnerable than other levels of observation. For this reason, and the reason stated above, I did not feel that they were an effective method of dealing with those inmates wanting to self-harm or attempt suicide.
14. There was a lack of accountability with the system of watches and it was not always clear at which intervals each patient had been observed. I therefore became involved in drawing up a protocol, which is now produced and shown to me as **exhibit JA3**. The purpose of this protocol was to address some of the perceived difficulties with the system of watches. It stated, for example, that within 24 hours of a doctor ordering a watch, the decision would be reviewed by a multi disciplinary team. The protocol proved to be an effective means of getting the doctors to develop more long term care strategies, as they did not like the idea of their decisions being scrutinized. The protocol was signed and approved by the SMO, the Head of Healthcare and the senior nurse, and eventually came in to force in 2003.
15. I ensured that all levels of watch were documented so that the nurse or officer on duty would have to sign to say that they had seen the patient at the required interval. I was made aware of situations where nursing staff had carried out their observations at regular 15 minute intervals. This was not helpful because the purpose was not to have a 15 minute interval between watches but simply to carry out the observations once during each 15 minute period, creating an unpredictable and therefore effective system of observation.
16. A further management difficulty arose from the use of healthcare wards. When I arrived there were three wards at Pentonville with about 76 in-patients in total, including the single healthcare cells. This was a lot higher than the average

number of patients in prison healthcare centres. It seemed that prisoners tended to stay there for a long time. This was not a good use of resources and was not good for the prisoners as the wards were in a different physical location to the cells, which meant that they were less likely to interact with staff and other inmates. I realised that the clinical staff were not interacting with prisoners in the same way that officers on the wings were. I believe that this was because most of the nurses had not worked in secure units or equivalent environments and were not sure how to deal with the challenging behaviour of some of the prisoners in healthcare. I think this meant that the nursing staff were generally not very confident in their dealings with healthcare patients. It seemed that inmates were prone to exploit this lack of confidence and would play up to the nursing staff more than they would to the prison officers.

17. Some inmates thrived in the wards on R1 landing. There were various reasons for this, including being able to bully the other patients into giving them food or tobacco. I saw inmates who, upon being discharged from healthcare, would immediately self-harm so that they would not be made to stay on the wing. I was told by other prison officers that there was at least one occasion when patients had staged a mock hanging so that the other patients could 'save' them and gain the attention of the staff and earn praise in the form of extra food or tobacco. I have never directly witnessed an incident of this nature throughout my time at HMP Pentonville. When I was told about this I was already committed to making significant changes in Healthcare. Clearly we needed a more productive regime for patients, and better overall management of patients.

18. In order to instil some of the discipline seen on the wings into the healthcare centre, I advertised for, interviewed and recruited five experienced discipline officers in 2000. The new officers were specifically chosen for their strong interpersonal skills and their ability to be firm when necessary. They were a welcome addition to healthcare and definitely had the desired effect on the healthcare population as well as on the nursing staff. I was able to measure this by noting the decrease in the number of alarms coming from the healthcare centre. Any member of staff can raise the alarm either by pressing the alarm button situated on an end wall in healthcare or by blowing a whistle and shouting their location. The alarm should be raised if a member of staff sees a fight or an assault on a prisoner or member of staff or if they fear that any of these things are going to happen. Once the alarm has been raised, one of the officers on the

landing with a radio would inform communications and security. Communications would then raise the general alarm throughout the prison. The allocation of the discipline officers in healthcare centre reduced the number of alarm bells from approximately three or four a day to one a month.

19. The next task I set myself was to reduce the number of healthcare beds. In 2000/2001 the number of in-patients had risen to about 76. This was disproportionately high, even for a prison hospital. In order to determine whether the number of beds could realistically be reduced, I reviewed the clinical needs of each patient in healthcare with the assistance of Registered Mental Nurse Dickson. We found that there were a significant number of patients in the healthcare centre who did not need to be there for medical reasons. I prepared a report of our findings, which is now produced and shown to me as **exhibit JA4**. My recommendation was that all those prisoners classed as 'non-patients' should be discharged from healthcare. My recommendation was accepted and arrangements were then made for all 'non-patients' to be returned to the wings gradually. This initiative enabled us to reduce the number of inpatient beds to around 43 and close the wards on R1 landing before the end of 2001. However, given the number of inmates in healthcare on open "F2052SH" forms (self harm at risk forms), we had to make sure that each inmate could be appropriately managed on the wings. We ensured that we had sufficient safeguards in place to support those we perceived to be at risk of suicide or self-harm by setting up a counselling service and regular support groups. The counselling was carried out on a rolling basis so that new arrivals or at risk prisoners would be able to fit into a session straight away.

20. I felt strongly that prisoners needed to get involved in the prison regime to the extent that they were able, even if they were not well. The engagement of prisoners in purposeful activities not only gave them something to do, but also made them easier to engage with and manage. This was clearly in the interest of both the prisoners and the staff. I felt that the best way to meet this need was to encourage prisoners to take part in classes or undertake some light work in the workshop such as assembling jackets for medical records or even to go to the gym if they were physically able. As part of the drive to provide purposeful activities, I decided to turn the old ward into a day care centre. In this centre we provided the counselling and support group services as well as some art therapy and pottery classes. Our Art Therapist, Pam Mellier, was really fantastic with the

prisoners. She did both one to one sessions and group therapy at HMP Pentonville and may also have worked at HMP Wormwood Scrubs at the same time. I did not have any additional money with which to provide these facilities. I cannot remember now where I got the money for art therapy from, but it might have come from the healthcare budget and I think that I may have taken money from the education budget to set up the pottery classes. As I did not have any extra funding, I struggled to find sufficient staff to cover these activities. Although I was enthusiastic about setting up the day care centre and the various classes, I would never have run an activity or class without an adequate number of staff.

21. The healthcare centre in 2001 was not a suitable hospital as it was a converted wing. However, until the new healthcare centre was built we had to make the best of the facilities which were available. The improvements that the Pentonville management team made in healthcare in 2000 to the cleanliness and lighting of the healthcare centre made a real difference to the look and feel of the place. I believe that we were doing our best to provide a suitable environment for the treatment of mentally ill prisoners, given the challenges that we faced. The ratio of staff to prisoners in healthcare was higher than anywhere else in the prison, which ensured that patients were well looked after. As I have explained, the healthcare staff were made up of a mixture of Registered Mental Nurses, Registered General Nurses and experienced officers, hand picked for their ability to effectively interact with prisoners.

### **Record Keeping**

22. Compared to the standards I was used to in the Navy, I believe that the Prison Service is generally quite poor at record keeping. Having said this, I do not think that HMP Pentonville is unique in experiencing difficulties in this area. What should be borne in mind is that HMP Pentonville is probably one of the busiest prisons in Europe and on any given morning we would have to locate and send out between 80 and 120 sets of Inmate Medical Records ('IMR') with the prisoners. To complicate matters further, all prisoners would have a prescription chart which would have to go with them. If a prisoner were receiving treatment, then his IMR and prescription chart would be kept with him on the wings or in the healthcare centre. If not, his IMR and prescription chart would be stored in healthcare centre.

23. When I arrived in healthcare in 2000, I found that it was difficult to keep track of the IMRs of the healthcare patients. In order to improve the situation we fitted a barn door on to the records room and had a logbook put on the door so that all records had to be signed in and out. Unfortunately, I cannot remember when this took place. In approximately 2002 or 2003 we even employed a former NHS records manager to try and improve the situation. However, records still went missing even then. I do believe that the introduction of the Egton Medical Information System ('EMIS') in late 2006 and Prison Service Professional Standards will really improve records management at HMP Pentonville.

### **Doctors Appointments and Referrals**

24. The appointments system at HMP Pentonville worked on the basis that each doctor would make a list of all the patients he wanted to see in a given session. An administrator would then collect these lists and compile a central list. A copy of the list would then be sent to each wing office. The wing officers would then show the list to the call-up officers so that they would be aware of which inmates needed to be unlocked to attend appointments each day.

25. The Did Not Attend ('DNA') rate for doctors' appointments at HMP Pentonville is around 40%. When I looked into this I came to understand that there were a multitude of reasons why a prisoner would not attend an appointment. On the most basic level, the initial complaint that prompted the inmate to make an appointment in the first place may have resolved itself. Additional reasons why prisoners were not able to attend appointments included short notice court dates, legal visits and social visits. The appointment may have also clashed with canteen visits, gym or exercise sessions. On rare occasions the failure to attend could even have been caused by miscommunication of the instructions to unlock between the wing officers and the call up officers.

26. In order to reduce the potential for miscommunication, HMP Pentonville now operates a free flow system on some wings between 7.45am and 8am every morning. During this time, certain internal gates are unlocked so that prisoners needing to attend medical appointments, education or work can walk to these locations by themselves.

27. Prisoners would be referred to psychiatrists, psychologists and other outside specialists by the doctors at HMP Pentonville, following either a ward round, case conference or a scheduled doctor's appointment. In 2001 HMP Pentonville utilised the forensic psychiatric services from Camlet Lodge on a sessional basis only. Each specialist would attend, broadly speaking, once a week to see and assess their patients. As they were not full time employees, prisoners would have to wait for their next visit before they could be seen. After the initial referral assessment had been carried out, the psychologist would often propose a period of monitoring before they recommended either a new course of treatment or, in extreme circumstances, transfer to a secure unit. In some cases this would take more than two weeks. The referral rate was a matter of general concern across the Prison Service but was not something that we could change as we had to work within the constraints of the NHS system in place. I believe that the Prison Service Health Task Force started collecting statistics on the monthly referral and transfer rates before 2001.

28. In order to improve the situation, the NHS drew up a preferred model for referrals from prisons. I should imagine that this came in to force in approximately 2003 or 2004. The idea was that in order to provide more efficient care for the mentally ill, prisons were given money by the Department of Health to establish a mental health in-reach service. I suppose that this roughly equates to a care in the community approach. This funding was to be used to employ social workers and Community Psychiatric Nurses. At a later stage in this initiative, prisons were required to use their healthcare budgets to employ full time consultant psychologists. I seem to remember that this commitment contributed to a large healthcare budget overspend for the year 2004/5.

### **Emergency Medical Response Team**

29. The Emergency Medical Response Team ('EMRT') was set up by Hospital Senior Officer Peter Hayward in around 2000. He had done a lot of trauma work and had a particular interest in paramedic trauma. He picked up on the fact that nurses are not normally trauma trained. They are either general nurses or mental health nurses but neither have accident and emergency training. As the Health and Safety Executive required a certain number of staff in the workplace to be first aid trained, Peter Hayward saw a way to combine both of these types of training. Peter Hayward was extremely self-motivated. He came to me with a really

impressive proposal for basic prison trauma and life support training with a view to setting up an EMRT. I thought that this was a very good idea and persuaded the Governor to give us the funding for a trauma response bag, which contained a defibrillator and the CPR equipment that we would need to set up the initiative.

30. I cannot remember now how the members of the EMRT were selected. Either we sent out a staff notice to find out who was interested or we simply trained those nurses and officers we thought would benefit. As each team needed a minimum of two members, I remember that we trained the two nurses on permanent night shift in order to ensure that a team would be on duty during every shift. The training Peter Hayward gave covered basic first aid as well as trauma training. It dealt with issues such as how to prepare for and respond to an emergency and how to use a defibrillator as well as more advanced 'first on scene' training. A handout from the Basic Prison Trauma and Life Support training is now produced and shown to me as **exhibit JA5**. As far as I am aware, it was the first time this kind of training had been offered anywhere in the Prison Service.
31. The EMRT operated using alarm response radios and followed an alarm response protocol that I had written. A copy of the Protocols for Mobilising the Emergency Medical Response Team is now produced and shown to me as **exhibit JA6**. The designated team is required to collect a radio each day from the Security department. Hotel 9 is the call sign allocated to the team. Indeed, the EMRT is sometimes referred to as the 'hotel 9' initiative as in the event of a medical emergency 'hotel 9' was called on the radio. The team would be informed by radio of the location and level of severity of a medical emergency. There are two levels of medical emergency: level 1 or level 2. Level 1 is the highest level of emergency, which is used to describe a prisoner who is so ill or injured that they are not able to walk to receive medical treatment. When the hotel 9 call is received, the EMRT would collect the trauma response bag, the portable oxygen cylinder and the anti-ligature scissors and attend the scene.
32. In 2001, the anti-ligature scissors were kept in a small key safe in the treatment rooms. The officer in charge of the landing would have the keys to this safe. They could not be issued to all members of staff as they could very easily have been used as weapons if they fell in to the hands of a prisoner. Prison Service practice has now evolved in this respect and the anti-ligature scissors have been replaced with an anti-ligature knife with a concealed blade known as the 'big fish'. The

blade is so called because it is shaped like a fish. All prison officers will be issued with these, because the blade is concealed and the knife cannot be removed if they fall into the wrong hands.

33. The EMRTs are still operating today, even though Peter Hayward is no longer at HMP Pentonville. I am very proud that I was involved in this initiative, which has now been adopted throughout the London area.

#### **Delay in building new healthcare centre**

34. As I was a temporary Principal Officer in 2000, I would not really have been exposed to the efforts made to secure funding for a new healthcare centre. Having said that, I do remember that Adrian Smith, the then Area Manager visited the prison with the then Prisons Minister, Paul Boateng, in around 2000 or 2001 and I remember that in healthcare we were all under the impression that the purpose of the visit was for them to decide whether funding for a new healthcare centre should be released. I understand that even once the funding had been released there were difficulties getting the building work started, as HMP Pentonville had to obtain permission to demolish a listed building.

#### **Policy changes in healthcare**

35. From a managerial perspective, the preparation for the transfer of responsibility for prison healthcare to the NHS in 2003 and the move to the new healthcare centre proved more problematic than the running of the old healthcare wing. I believe that this may have been because of the sheer volume of changes necessitated by the assimilation into the NHS. In 2004, the responsibility for commissioning healthcare services was transferred to the Camden and Islington Primary Care Trust. The importation of NHS standards and resources has led to significant changes in the running of healthcare at HMP Pentonville, such as the recruitment of a General Practitioner as the clinical lead and the provision of more up to date equipment.

#### **Move to new healthcare centre**

36. I think that we must have moved into the new healthcare centre some time after responsibility for healthcare was passed to the NHS in 2003. We were originally

due to move in to the new healthcare centre in March 2004. However, there were inevitably delays, as there are with any contract of this size and complexity. Even when the centre had been built and was ready for use we found that we were not able to move in, as the gated cells did not have proper lock backs on them, some of the connecting doors were not secure and the heating did not work. I remember that the Governor and I were both keen to get healthcare moved into the new centre before the next HMCIP inspection took place. I cannot remember exactly when this would have been, but I believe that the move would have taken place by mid 2004.

### **Staffing**

37. I was keen to create a new management structure in the healthcare centre that was both proactive and supportive. I was fortunate in that the Prison Service Health Task Force had agreed to second a NHS consultant to HMP Pentonville before I arrived in healthcare. The consultant was called Steve Ganon and he took up post around three months after I had joined healthcare. Steve Ganon was very enthusiastic about the changes I was implementing. He helped me to recruit an I Grade nurse called Kay George to act as matron. I cannot remember exactly when this was but I believe it would have been around April 2001. The idea behind recruiting a matron was to give the nursing staff some professional direction and establish a framework for clinical governance and supervision.
38. I remember that when Steve Ganon arrived, he was so pleased with the improvements we had made in healthcare that he said he could not understand why he had been asked to assist. He was seconded to HMP Pentonville for six months, during which time we developed a good working relationship. I found him a very helpful person to have on my team and his clinical support was invaluable. He understood the rationale for the changes that I was trying to implement and was able to comment on them and work out how to implement them from a clinical as well as a managerial perspective.
39. I did not think that the staffing levels in the healthcare centre at HMP Pentonville were significantly lower than anywhere else in the prison between 2000 and 2002 or that there was an abnormal level of sick leave being taken by staff in comparison to other big local prisons. However, I did take steps to reduce the sick leave level and noted in the healthcare action plan (exhibit JA2) that I would

review the situation again in February 2001. This was achieved by ensuring that prison service policies for managing attendance were actually being correctly implemented. Attendance levels did improve as a result of this action.

40. Although I did not think that staffing levels were particularly low, I took the view that the healthcare staff resources were not being efficiently used. The investigation into the staff rota system known as Staff Planning And Resources or 'SPAR', which I conducted before I joined healthcare, helped me to form this opinion. My investigation found that not all staff were doing their fair share of evening duties and that some nurses were being given time off in lieu on weekends and then coming in to work overtime to claim a higher rate of pay, which was totally unacceptable. The Healthcare Principal Officer would sign off on their time sheets. I am not able to clearly recall how this came to my knowledge but I was made aware that the Principal Officer was having an affair with the senior nurse at this time, which made the situation very difficult to manage. I believe that both parties have now left the Prison Service and that neither would have been working in healthcare in 2001.
41. When I assumed responsibility for staffing issues in healthcare in 2001, there was already a staffing profile in place. I think that it would be extremely difficult to locate this profile now. I remember that the profile was divided into officers and nurses so that there was always a good mix on each shift and that there was a high staff to prisoner ratio. The most recent profile carried out at Pentonville was about a year ago so I would imagine that the previous set of profiles would have been taken about two to three years before that.
42. I would like to clarify the comments that I made during my tape-recorded interview with the Assistant Ombudsman regarding the quality of agency staff. When I said that permanent members of staff working with agency nurses had to work twice as hard I meant simply that they would have to escort them around the building and would have to take time out to familiarise the agency staff with the systems in place and the particularities of individual patients. We only really used agency staff to carry out watches on at risk patients. If we needed to take on a temporary nurse to cover for a permanent member of staff, we would tend to use the same nurses over and over again as we knew that they would be able to

carry out the tasks required and would be familiar with the procedures in place at HMP Pentonville.

43. What sometimes gets missed is how much staff cared about what was happening in healthcare. During my time in healthcare we brought in some people who were really passionate about what they were doing. The amount of effort that some of the staff were putting in was fantastic and made all of my hard work seem worthwhile.

### **Induction and Professional training**

44. Induction training for new prison officers has traditionally taken place off site. On arrival at Pentonville, new recruits are given a line manager who they can discuss their development needs with as well as any concerns they might be having about the work. Agency nurses would have received induction training on site. I believe that in 2001, Tony Smith, the nurse manager, would have carried out their induction. I am not sure what this course covered but I seem to remember that there was a check sheet which would be signed to show that they had been given a full health and safety briefing and had been told how to raise the alarm for example. I must admit that we tended to use the same agency nurses as much as possible, in order to ensure some continuity, and so that after their first few shifts at HMP Pentonville, they would be well acquainted with healthcare practices and procedures.

45. In 2001 the Prison Service had key performance targets and mandatory minimum staff training requirements. Key performance targets are set by Prison Service Headquarters in negotiation with the Prison Service Board. The targets regulate all aspects of prison performance. I believe that the key performance target for training at this time was six days per year per member of staff. I would think that HMP Pentonville was meeting this target but it is unlikely that records of these targets would have been retained by Prison Service Headquarters after all this time. I believe that the mandatory minimum training consisted of Suicide Awareness and Control and Restraint training. This was carried out by staff on an on going basis. I believe that nurses would also have undertaken this mandatory training in addition to the continuing professional development course they needed to attend in order to keep their qualifications up to date.

## **Detoxification Policy and practice**

46. In 2001 HMP Pentonville's detoxification ('detox') programme was run by a foreign qualified doctor called Ashwin Balabhadra and was managed by Principal Officer Eamon Dowling. I believe that in 2001 HMP Pentonville was operating a methadone based detox over either 7, 14 or 28 days. They were successfully detoxing approximately 3,500 prisoners a year on this basis. This number is even more impressive when you realise that this figure is higher than the total number the NHS detoxes in the whole of southeast England in any given year. As it was so successful, HMP Pentonville was reluctant to change its programme when it was suggested that prisons in the London area should all switch to a more complicated Librium based detox. I understand that detox policy has changed a fair amount now that healthcare services are the responsibility of the Primary Care Trust and that the detox programme is now contracted out.

## **Suicide awareness**

47. All staff received suicide awareness training, which told them what behaviours to look out for amongst prisoners. The training was mandatory and was refreshed on a rolling basis but to be honest, the issues that it covered really did not need to be spelt out to the officers and nurses working with the prisoners in the healthcare centre. For the most part, this training simply reinforced their pre-existing knowledge. It is impossible for me to quantify the efforts that staff went to to take care of prisoners and it was apparent that suicide awareness was really just a part of their natural empathy and commitment to prisoner welfare.

48. Tony Madden headed the mental health in-reach team. His team delivered some excellent mental health awareness training for both nursing staff and officers. The training really helped staff understand the reasons why someone might want to self-harm or attempt suicide and helped officers understand the situations in which a mental health referral might be appropriate for at risk prisoners. Unfortunately, I cannot recall when this training took place.

49. The management of prisoners committed to self-harm is a constant challenge and is taken very seriously by all the staff working in healthcare. Staff are constantly trying to balance the need to protect each prisoner's individual dignity and decency with the need to prevent them from either harming or killing

themselves. If staff were concerned that an inmate was really going to seriously self-harm or attempt suicide they would temporarily put him into either AS1 or AS2, the semi furnished cells. These were east facing cells located on the R1 landing, next to the healthcare cells. They had thick glass bricks in the window so that they were not easy to break. However, these bricks reduced the flow of light into the cells and made them darker than the standard cells in healthcare. These cells were safer for at risk prisoners as they had fewer ligature points than ordinary cells. They contained only a bed and stainless steel fittings. Stainless steel was used, as inmates could break ceramic fittings and use them to self-harm. Although the cells were only semi-furnished, we tried to make them as comfortable as possible and would put cardboard tables and chairs in to the cell where possible. The AS cells were only used for as long as strictly necessary to manage the individual's immediate crisis. However, as there were only two of these cells and a significant number of at risk prisoners, they were nearly always in use.

### **Communication of Risk**

50. I never really had anything to do with the workings of the escort system for prisoners. However, I believe that risk would be communicated between the courts, escort services and the prison by means of the Prisoner Escort Record ('PER'). The PER would be filled in by court staff and escort staff and would arrive at reception with the prisoner. In my experience, what tends to happen on reception is that two escort staff arrive with the prisoner. The first would sort out the prisoner's property whilst the second would introduce the prisoner, provide his PER and give a verbal handover to the reception staff. The PER is closed once a prisoner has been received and so does not follow him through the prison. However, if a new prisoner had been deemed to be at risk of self-harm, the court staff or escort staff would open a F2052SH. This would be handed over and discussed with reception staff at the same time as the PER. The F2052SH would then stay with the prisoner for as long as it remained open.

### **Use and effectiveness of F2052SH**

51. The F2052SH process was in place at Pentonville until late 2005, when it was replaced with the Assessment, Care in Custody and Teamwork plan known as ACCT. A F2052SH form was opened whenever a prisoner was thought to be at

risk of self-harm or suicide. The form was not only opened by prison officers but also by anyone who came into contact with the prisoner such as court staff, escort staff and teachers as well as by doctors and nurses. The prisoner's well-being would then be reviewed at the intervals set out on the flow chart on the inside cover of the form. An open F2052SH form would go everywhere with an inmate; to court, to healthcare, to work and to classes and anyone who interacted with the prisoner was encouraged to write on the form. This created a large administrative burden, as there would be between 4-6 prisoners on each wing with open forms at any one time.

52. If the F2052SH form was opened for a prisoner on one of the wings, the form would stay on the wing and the wing manager would hold the case conferences and decide when to close the form. There would usually be a doctor or a healthcare officer present at a case conference. However, local policy at HMP Pentonville at the time was that if a F2052SH form was opened whilst a prisoner was in healthcare, the case conference would take place as part of the healthcare ward round and the form could only be closed by a doctor. In either case, the prisoner would be asked to attend a case conference where it was felt that he was calm and stable enough to be consulted about his care and treatment needs. Once a decision had been made to close a form, a discharge plan would be drawn up. This would give suggested strategies for managing the prisoner and would for example highlight behaviours that staff should look out for on an ongoing basis.

53. The Suicide Prevention Committee monitored the use and effectiveness of F2052SH. I am afraid that I do not remember when the committee was put into place. Its role was to carry out a continual evaluation of F2052SH procedure by monitoring the quality of entries on the forms and the volume of forms opened and closed. I believe that the committee met monthly and was chaired by one of the assistant governors. As well as the Suicide Prevention Co-ordinator, representatives from residence, healthcare and probation would also attend. Copies of minutes of the Suicide Prevention Committee meetings from October 2001- March 2002 are now produced and shown to me as **exhibit JA7**. The minutes show that Dr Talat and Kay George regularly represented healthcare at these committee meetings. These minutes set out the statistics collected by the Suicide Prevention Co-ordinator and refer to action taken in individual cases of concern.

54. I think that it was Governor Davies who set up the internal audit team at HMP Pentonville and established a rolling programme of audits when he first became governor because he wanted to find out what was really going on the ground. He recruited Chris Jones to head up the internal audit team but I could not say with any certainty when this would have been. We used the internal audits to help ensure that we were meeting audit baselines and key performance targets in areas such as suicide and self-harm and to prepare for full Prison Service audits. In order for an internal audit to adequately prepare a prison for a full Prison Service audit, it is essential that it be conducted to a very high standard. Indeed, even trivial non-compliances such as using an undated document are noted.
55. Copies of the March 2001 self audit table and self audit sheets are now produced and shown to me as **exhibit JA8**. The table sets out the Prison Service Standard in this area, namely that Prison staff will identify and provide care and support to those prisoners at risk of suicide and self-harm. The table then sets out a list of the key audit baselines which need to be met in order to achieve the standard. The table further shows whether the internal audit team felt each baseline had been met and comments on ways in which HMP Pentonville's practices could be improved. Following an internal audit, a summary of proposed action and an action plan will be drawn up to ensure that all areas of non compliance are rectified. A Summary of Proposed Action and a draft Action Plan from the March 2001 internal audit are now produced and shown to me as **exhibit JA9**.
56. By adopting this continual process of monitoring and evaluation, HMP Pentonville is able to ensure that audit baselines are being met, not only with regard to suicide awareness but also to all aspects of prison life. The effectiveness of the internal audit process was confirmed when HMP Pentonville was classed as 'double good' in two Prison Service audits during the period 2000-2003. I cannot exactly remember the dates. A 'double good' meant that both regime security and standards were assessed as 'good'. This was a particularly remarkable achievement for HMP Pentonville as it was the first time that a big local inner city prison had achieved this rank, at that time, as far as I am aware.

Signed.....



Position.....

Head of Human Resources

Date.....

3/4/07

**Prisons and Probation Ombudsman**

**Investigation no 01/2007**

INVESTIGATION INTO THE NEAR DEATH IN CUSTODY OF 'D' ON 27  
DECEMBER 2001

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**INDEX OF EXHIBITS TO WITNESS STATEMENT OF JOHN ATTARD**

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<b>Tab</b>	<b>Exhibit</b>	<b>Description</b>
1	JA1	Extracts from Observation Book December 2001
2	JA2	Healthcare Centre Manager's Action Plan, reviewed 31 October 2000
3	JA3	HM Prison Service/NHS Healthcare Protocol regarding Levels of Observation 18 May 2003
4	JA4	Report by John Attard regarding the Classification of Prisoners in Healthcare 8 October 2000
5	JA5	Basic Prison Trauma and Life Support Training Notes, undated
6	JA6	Draft Protocols for Mobilising the Emergency Medical Response Team, undated
7	JA7	Minutes of Suicide Prevention Committee Meetings October 2001-March 2002
8	JA8	Self Audit Table and Self Audit Sheets March 2001
9	JA9	Summary of Proposed Action and Draft Action Plan following Internal Audit March 2001