

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 PETER HAYWARD

I, Peter Hayward of *Prison Service College, Newbold Revel, Rugby, CV23 0TH*,
WILL SAY AS FOLLOWS:

1. I am currently the Deputy Head of Offender Management Training at the Prison Service College but I was the Officer in charge of the healthcare centre at Her Majesty's Prison Pentonville ('HMP Pentonville') on 27 December 2001. I can remember very little about Mr D but am happy to assist the Prisons and Probation Ombudsman with his investigation into the facts and circumstances surrounding Mr D's attempted suicide as far as possible.

Background and qualifications

2. I joined the Prison Service in 1989 as a Prison Officer at HMP Pentonville. I was a Discipline Officer in A wing until I joined the healthcare centre in 1991. I spent the next 17 years of my career in healthcare at HMP Pentonville, as a Healthcare Officer between 1991 and 1998 and then as Senior Healthcare Officer between 1998 and 2003. In order to qualify as a Healthcare Officer, I attended a 6 month

1

training course at Her Majesty's Prison Wormwood Scrubs. In 1991 this course was considered to be equivalent to the training given to state enrolled nurses. It covered all of the duties nurses performed in practice and involved classes in anatomy and physiognomy and the study of physical and psychiatric illnesses.

3. I passed the Prison Service board and was promoted to Healthcare Principal Officer in 2003. In the same year, I was seconded to the London Area Office to develop the Trauma and Resuscitation Course that I had written. I was based in the training unit at HMP Pentonville. I was then seconded to Prison Health (now known as Offender Health Unit) in 2004 on a temporary promotion to Governor Grade Manager F, but during this time I still remained based at HMP Pentonville. In April 2006 Prison Health withdrew the funding for the Trauma & Resuscitation Course and I returned to HMP Pentonville as a Governor Grade Manager F. In July 2006, I took up my current post at the Prison Service College.

Healthcare at Pentonville in 2001

4. In 2001, the healthcare centre was housed in R wing. This was supposed to be a temporary location but we ended up being there for a long time. The healthcare centre occupied R1 and R2 landing and possibly also some of R4. R wing was a normal prison wing and so it had not really been adapted for use as a healthcare centre. The cells were not standard healthcare cells; they were just normal wing cells. We set up an x-ray room and clinic rooms but none of these were purpose built. The wing was quite dark and could sometimes be noisy as there was quite a rapid turnover of prisoners, the majority of whom had psychiatric problems. They were housed on R1 whereas the physically ill were located on the R2 landing. It really was not ideal, but it was not dangerous. At the end of the day,

we just made the best of the facilities that we had, as it was the care that we were giving which was key, so the building was of secondary importance to us.

5. When Gareth Davies became the governing Governor in 2000, he showed that he was committed to improving healthcare at HMP Pentonville. He changed the management team and one of the first things that they did was to organise a programme of deep cleaning and painting, which helped to cheer the place up.

Working culture

6. There were some tensions between the nurses and the healthcare officers at this time. I believe that these tensions were the result of the moves to abolish the post of healthcare officer in the early 1990's. I think that it was felt that bringing nurses into the prison environment would put a more professional face on prison health provision. As a result, the Prison Service stopped recruiting and training healthcare officers and so the existing healthcare officers became disenfranchised. The number of healthcare officers in the Prison Service fell dramatically as a result. It then became clear that these officers played an important role in Prison Health as they bridged the gap between the clinical care given by nurses in healthcare and the supervising presence and proactive prisoner interaction which came from the officers on the wings. I understand that this was an issue throughout the prison estate.
7. On top of this, it was difficult to recruit and keep good nurses in the Prison Service so we would at times be quite heavily reliant on agency nurses. We had several difficulties with the use of agency staff. They were very expensive for us to hire. There were also limits to how helpful they could be, as they could not carry keys. On the whole, it was not that they were not good nurses, but more

that they did not know how to deal with the prisoners. The majority of agency staff would be used to carry out constant observations. However, in some cases due to lack of staff we did have to detail them to cover operational tasks.

8. By the year 2000, it was clear to me that the three or so remaining officers in healthcare were having to do everything that needed doing in the healthcare centre, from unlocking prisoners and interacting with them, to providing discipline and control and restraint, to carrying out discrete medical tasks such as lifting and moving prisoners as the nurses did not have sufficient experience of the prison environment to do this effectively themselves.

9. When Gareth Davies became Governor, I decided to take a new proposal to him and John Attard. I felt that recruiting discipline officers to specifically work in the healthcare centre would ease the strain on the officers currently in healthcare and would help reduce our reliance on agency nurses. They would also be able to hold keys and would interact well with the prisoners. Gareth Davies and John Attard were very enthusiastic about this proposal, and recruited 5 new discipline officers into the healthcare centre in 2001.

10. I was aware that this might create some tension with the nursing staff as there was a culture in healthcare at that time of a number of the nursing staff trying to belittle the healthcare officers as they were not medically qualified. This was a matter of professional snobbery in my opinion. In order to minimise these tensions as far as possible, I made sure that the discipline officers were all trained in my Trauma and Resuscitation Course before they joined the healthcare centre.

11. We found that the discipline officers were a very welcome addition to the healthcare centre. They had a really positive attitude and were willing to get stuck in and do what ever was required to get the job done. There was no strict allocation of duties between the healthcare officers, the nurses and the discipline officers. The only hard and fast rule was that discipline officers could not give out medication, as they were not qualified to do so. In recognition of their hard work, I approached Governor Davies and requested that they be given the healthcare officer specialist allowance even though they were not fully-fledged healthcare officers. The Governor agreed. This raised their morale and made them feel part of the healthcare team.

12. At around this time, an H grade nurse called Kay George was also recruited to provide some direction for the nursing staff. She was extremely proactive and enthusiastic and was very good at bringing the nursing staff and the discipline staff together.

13. The assimilation of Prison Health into the National Health Service ('NHS') was also taking place at this time. In order to identify how our practices could be further aligned with the NHS, a nurse consultant called Andy Graham was seconded from the NHS to HMP Pentonville. It became clear that Prison Health was never going to be identical to the NHS because it has to operate in an environment where security is of central importance. So there is always going to be some difference between the two models.

Training

14. HMP Pentonville ran both suicide awareness and suicide prevention training courses. I think that these were either half day or full day courses with a rolling

refresher programme on either Wednesday or Thursday afternoons. There was a prison-wide push to get everyone trained in Suicide Prevention, but I did not attend for some reason. From what I can remember I attended a module on the self-harm at risk form ('F2052SH') in 2001. To be honest, the best awareness training that we had was dealing with those at risk on a daily basis. Staff had a clear idea of the mechanics of the F2052SH and how to use the document effectively. They were comfortable opening the forms and following the necessary procedures.

15. The prison used to hold training afternoons which healthcare officers, discipline officers and nurses were obliged to attend. However, these sessions were of limited value, as they did not cover issues which were relevant to healthcare. We thought that the best way round this was to start running our own training afternoons. There would only be two or three members of staff at each session, as we had to maintain our staffing detail. That said, we found that the small group training was highly effective. Either the lead nurse or I would provide the training. I would cover topics like Cardio Pulmonary Respiration ('CPR'), defibrillation techniques, awareness of the emergency bag, how to deal with epilepsy or diabetes, whilst she would present on nursing topics such as tuberculosis or infection control. We would also use one afternoon a month to look at the deployment of the Emergency Medical Response Team ('EMRT') over the last four weeks as part of our continued process of learning and development. These sessions were particularly useful for the discipline staff as none of them had any medical training other than the Trauma and Resuscitation Course. The training helped them to plug any gaps in their knowledge and made them feel like an effective part of the team.

System of responding to incidents of self-harm

16. It is assumed that because staff are based in healthcare that they are medically trained and that they will just know how to respond in an emergency. This is not true. Unless doctors and nurses are trained in emergency medicine, they do not always know how to respond to an incident of serious self-harm. It really is a separate specialism. When I became a Healthcare Officer, I often found that I would be called to deal with an emergency by officers on the wings who would stand back and leave me to deal with an incident because I came from healthcare, when in reality, I did not have any more knowledge or specialist training than they did. This meant that we were under a great deal of pressure to know what to do in such situations but were not fully equipped to take on this level of responsibility. I decided that I wanted to qualify as a first aid instructor in approximately 1993/4 after I was involved in a resuscitation attempt which ultimately failed.

The development of the Emergency Medical Response Team

17. After the failed resuscitation attempt, I felt that I needed to be better able to deal with medical emergencies. I therefore trained as a first aid instructor so that I could teach first aid to the staff at HMP Pentonville. I then applied for an Emergency Medical Technicians Course but was refused funding by the Prison Service. I knew I wanted to do this course, so I funded it myself and even used my annual leave to complete some of the training.

18. In 1998, the American trauma course, known as the Basic Trauma Life Support course ('BTLS') was on trial in the UK. I attended and passed the course at my

own expense and was approached by the organisers about becoming an instructor. I contacted Dr. Yisa, the Senior Medical Officer at HMP Pentonville at the time and he agreed to fund the instructor course for me. I became one of only 34 BTLS instructors in the whole of the UK at that time, and the only instructor in the Prison Service.

19. I then obtained a doctor's level diploma in Immediate Care Management. I did manage to obtain some funding for this from the Prison Service. Dr Yisa was a great help with this too, and he provided funding for me whenever he could. He was very enthusiastic about having the only BTLS trainer in the Prison Service and encouraged me to carry out a training needs analysis for the BTLS course. The results of this analysis were very positive. As it was seen to be difficult to take what was essentially a roadside pre-hospital care course into the prison environment, I wrote a prison based Trauma and Resuscitation course. I then tried to get the course accredited by the Prison Health Task Force and the Prison Service College in 1998 but this was not successful. The current version of this course is now produced and shown to me as **exhibit PH1**. Unfortunately, the 2001 version is no longer available.

20. I gave up on this route and decided to deliver the course at HMP Pentonville under my own initiative, with the support of Gareth Davies and John Attard. They really helped me to champion the cause. I ran the course at HMP Pentonville through an outside company, Life Skills Medical. They would send independent medically qualified assessors to assess my BTLS students and to make sure that they were medically competent. This company provided me with all the equipment that I needed to set up the training at HMP Pentonville.

21. The Trauma and Resuscitation training gave participants the ability to use simple airways, administer oxygen, identify and treat people with spinal trauma, thoracic chest trauma, abdominal trauma, pelvic trauma or long bone fractures. It was useful because although there was plenty of Prison Service guidance about how to prevent an incident of serious self-harm or a suicide attempt and what to do after the event, there was nothing really available on how to actually cut someone down and how to open an airway on someone who has been found hanging. Safer Custody Group have since produced a very good DVD on first response, where they briefly demonstrate cutting someone down but in my opinion not enough was made of the possible cervical-spine problems which can arise.
22. The EMRT went live in approximately July 2001 and was known in the prison as HOTEL 9 as this was the call sign that staff would use if they needed to call out an EMRT. There were initially about 18-20 trained members of staff and a team would be called out about 4 or 5 times a week. By the end of 2001, we had trained enough staff to enable us to have an EMRT on every shift. The first emergency response bag used by the team was purchased with funding provided by the Governor. The bag contained a selection of oral and nasopharyngeal airways, an ambu bag with 3 different sized masks, a 100% non re-breathable oxygen mask, a pulse oximeter, saline, a selection of cannulars, a blood pressure cuff, stethoscope, ET tubes, needles and syringes, ligature cutters and a selection of drugs including epinephrine, glucagon, atropine, diazepam, naloxone and a ventolin nebulisor. The bag also contained c-spine collars. We also kept a defibrillator and long board with the kit.
23. I should explain that only those with advanced training, such as myself, were able to administer fluids and drugs. This was quite trend setting as to my knowledge only NHS paramedics were using these sorts of drugs pre-hospital at the time. I

believed that all Healthcare staff should be trained to give these drugs and use this kit as we are always at the mercy of ambulance response times. In some instances it can take an ambulance quite some time to arrive at an establishment, to actually gain access to the prison and then get themselves and their kit to the scene of an incident. That is why I developed the course. It was essentially to buy the casualty time and stabilise them whilst waiting for an ambulance. For example, if a prisoner overdoses it is essential to give them an opiate inhibitor, Naloxone, as soon as possible. If staff are not trained to recognise an overdose or give the medication required the prisoner will go into a state of respiratory depress which means you then have a full blown resuscitation on your hands, which could have been prevented if the Naloxone had been given.

24. My Trauma and Resuscitation course eventually got seen by the Area Health Adviser for London. She agreed to co-sponsor the course with Governor Gareth Davis and the Area Manager at that time, Bill Duff. This meant that the course could be submitted to the Prison Service College for accreditation. In 2002 I was still the only qualified trainer, so in 2003 I was actually attached to Prison Health to roll the course out nationally.

25. Unfortunately, in 2006 the funding for the course was withdrawn by Prison Health after the transfer of responsibility for prison health to the NHS, even though establishments up and down the country had booked courses through to September 2006. This decision is a very disappointing one but I understand that this is due to uncertainty as to what should correctly fall within the budget of the Prison Service and what is now the responsibility of the Primary Care Trusts ('PCT'). As far as I understand, healthcare training is now the responsibility of the PCT, so although there is still a high level of demand for this training within the Prison Service, the PCT are not willing to fund it and instead provide their own.

course, known as Immediate Life Support training. However, this training does not include basic trauma care or the use of advanced trauma equipment and does not teach how pre-hospital care should be provided in the prison environment. It simply provides students with a basic knowledge of CPR and the use of the defibrillator.

Suicide and Self- Harm at HMP Pentonville in 2001

26. I cannot remember if suicide or self-harm was a particular problem at HMP Pentonville in 2001. Unfortunately, self-harm is a matter of fact in prisons, and as a healthcare centre we would see self-harmers on a daily basis. There were 18 beds on the R1 landing in 2001, and these were used for those with physical or mental illnesses, so a lot were taken up by the most serious self-harmers. There were also a great number of self-harmers being managed by officers on the wings so deciding which self-harmers should be located in healthcare always involved difficult judgment calls, particularly when you bear in mind that what works for some inmates will not work for others.

27. What we used to do was really just try to interact with them as much as possible. It was very frustrating if, in spite of all this, a prisoner continued to self-harm. Sometimes, no matter how hard the staff worked, a prisoner would continuously self-harm. We did not use cell sharing as a self-harm minimising strategy at that time in healthcare. We did use the special cells. AS1-AS4, but by 2001 only AS3 and AS4 were in use. As far as I can remember, AS1 and AS2 were being used as a treatment room and a storage space in 2001. AS3 and AS4 were semi-furnished safer cells that we would use if we felt there was no other way to keep an at risk prisoner safe and get a violent or truculent prisoner to calm down. This was seen as a short term, immediate measure only. Any quick decision to move

a prisoner to a safer cell would need to be authorised by the duty doctor. We followed a procedure similar to the operation of the segregation unit if we were going to put a prisoner into these semi furnished conditions.

The identification, assessment and care of self-harmers: the use of the F2052SH self-harm at-risk form at HMP Pentonville in 2001

28. Identifying an inmate as at-risk of suicide and or self-harm is usually based on a personal judgement call of a member of staff, through their interaction with the inmate. Once a member of staff had identified an inmate as at risk of self-harm, they would open an F2052SH. The inmate would then be seen by a member of the healthcare staff who would decide which location would be most suitable for them until they could be seen by a doctor. In the vast majority of cases, a doctor would see the inmate straight away. The doctor would then confirm the location and decide on the most appropriate level of observations for the prisoner. If the doctor were not available, the F grade nurse or senior officer would decide on location until this could be approved by the doctor.

29. The process of assessment for those at risk was a continuing one. 72 hours after the F2052SH had been opened, there would be a multi-disciplinary case review. I was involved in case reviews during my time in healthcare at HMP Pentonville. Dr Yisa would usually hold these reviews on a Tuesday and Thursday morning. They were normally attended by a healthcare worker, all the doctors and the pharmacist. The team would go through the F2052SHs for those located in healthcare one by one and have a look at the prognoses and the care plans. It was not normal for the prisoner to attend, but that said, I have been involved in reviews where prisoners have attended. At the review, support plans were drawn up by the doctor dealing with the case and the nursing team on duty on that day.

The doctor would then decide whether the prisoner should remain on an open F2052SH and whether he should remain in healthcare or be located on one of the wings.

30. I believe that the F2052SH process was pretty effective and that it set out a good framework for follow up action. However, we did have some logistical problems with the process. Sometimes it was impossible to carry out all the necessary reviews within the 72-hour period, as the review was largely dependant on when the relevant members of staff were available and whether they could be released from their detail. However, the key staff members at any F2052SH review were always the doctors and the healthcare staff.

31. As officers, we sometimes found the F2052SH rather unclear. For example, if we suspected that the at risk individual had just made a flippant comment when he said that he wanted to die, we would still need to open a form and follow the process through to its conclusion. This was frustrating for us but we all felt that it was better to be safe than sorry so always erred on the side of caution. Unfortunately, I cannot comment on the operation of D's F2052SH, as this document cannot now be located.

Management of those at risk of suicide and or self-harm

32. It is a sad reality that irrespective of the policies implemented and protocols drafted, there is no way that incidences of serious self-harm and suicide can be completely eradicated. There is no perfect system. We do the best that we can to manage those at risk of self-harm by including them on an open form F2052SH until the crisis has passed. It should be noted that even putting a prisoner on a

constant watch can be very intrusive and dehumanising for them and that step should not be taken lightly.

System of referrals

33. In 2000/2001, we were referring a lot of prisoners to outside hospitals and secure psychiatric units. Either we were holding inmates who were due to be sectioned under the Mental Health Act or who had already been sectioned but were waiting for a bed to become available. At times this put a strain on our resources, as we were often instructed not to medicate these distressed prisoners until such time as a representative from the outside hospital could come to HMP Pentonville to assess them. So they needed a lot of care and monitoring until their transfer.

Observations

34. I believe that in 2001 the system of observations was regulated by Standing Order 13. The general level of observations for prisoners in healthcare was 30 minutes. The section entitled Special Supervision from Standing Order 13 is now produced and shown to me as **exhibit PH2**. This states that all prisoners seen to be at risk of suicide or self-harm are to be under 15 minute observations. The next step up from this is the 15 minute documented watch. This means that the nurse has to sign a sheet to say that they have observed the prisoner at irregular 15-minute intervals and note any comments they have about the inmate. The only observations more intensive than these are constant observations. These are essentially one to one observations where a nurse will continually observe a prisoner over a period of time.

35. The doctor would determine the level of observations suitable for each prisoner when he assessed them. However, as the Senior Officer in charge of the landing, I would make the decision to increase the level of observations on a prisoner if necessary. I preferred to err on the side of caution when ordering an increased level of watch, on the basis that the doctor could always reduce the level of watch on his next round if he thought that it was excessive. In fact, there have been times when an entire healthcare landing has been put on constant observations.

36. Obviously, the costs involved in placing an individual on a constant watch were enormous and so a senior management protocol was implemented in order to ensure the accountability of the decision making process involved in ordering a constant watch. This protocol is now produced and shown to me as **exhibit PH3**. This basically meant that in practice you had to have a senior manager's permission before you could order a constant watch. I do not remember exactly when this came in to force but I note that it is dated May 2003.

37. Having said this, I did not find that ordering a constant watch was always the best approach for the psychologically vulnerable. There has been a great deal of debate within the Prison Service as to whether constant observations are justifiable, as they are extremely intrusive for the prisoner and do not necessarily help identify the source of the prisoner's problem.

Record keeping

38. I thought that the reliability of the record keeping at that time was very much dependant on who was filling in the forms. Some members of staff were very good and made meaningful and informative entries but others did not. The lead

nurse, healthcare manager and the officer in charge of the healthcare landing were responsible for checking the quality of these entries.

39. There could be up to six different sets of documents relating to each prisoner which would have to be updated and reviewed on a daily basis. The Observation Book, the Inmate Medical Record ('IMR') which would be completed by the doctor, the care plan which would be updated daily to document a prisoner's medication and any clinical interventions, the F2052SH if the inmate had been identified as at risk of suicide or self-harm and the documented watch sheets if this type of watch had been ordered and also the prisoner's medication chart. Although each of these sets of documents had a different focus, there would be a great deal of duplication in the nature of the entries made. The F2052SH forms would be checked daily by the Duty Governor who would sign the form to say that the necessary reviews had been completed. The duty Governor would also sign the Observations Book every day.

40. The F2052SH stayed with the prisoner but all of the other forms, once completed, would be stored in the office. When a F2052SH was closed, it would be attached to the prisoner's core record, known as the F2050. When a prisoner was discharged from the prison, his IMR would be sent to the IMR office. When a prisoner was being transferred to another establishment or taken to court, his records would all travel with him. On a daily basis there would be around 130 sets of records coming into and going out of the prison. Sometimes sets of records would not return with the prisoner. To help keep track of the records, we put in place a system for signing them in and out. When records were misplaced, we usually found that it was the doctors who would take out records and simply forget to put them back. It was unfortunate that prisoner records would sometimes go missing. However, I think that the introduction of the Electronic

Medical Information System ('EMIS') will really help with the quality of record keeping as it will allow healthcare staff to pull up a prisoner's medical records on screen. This will be particularly helpful, as the computer will be linked to the NHS database so that staff will have immediate access to prisoner's community health records.

41. The Prisoner Escort Record ('PER') was a form that was generated by security for those prisoners being brought in to or taken out of the establishment by private escort. Healthcare staff were supposed to put comments onto the form of an outgoing prisoner regarding their risk of suicide or self-harm and enclose their IMR in a sealed envelope. I did not have any experience of receiving PER's from escort staff but I seem to remember that there were some concerns that they were not filling out the paperwork completely in all cases.

42. Better record keeping would improve the quality of the Prison Service's audit trails, and is extremely important. However to my mind, the crux of the matter is the quality of care provided to healthcare prisoners, particularly those at risk of self-harm. The best means of assessing whether a prisoner is at risk is to look at the individual in front of you. For me, the key is the quality of the staff delivering the service on the ground. The better quality these are, the better the quality of assessment will be and the lower the self-harm rate will be.

Role and responsibilities

43. I was the Senior Officer in healthcare in 2001. This meant that I was the officer in charge of the healthcare centre when I was on duty. I was also in charge of the EMRT whenever I was on duty so I would select 2 or 3 members of staff to be part of the EMRT with me. One member of the team would be responsible for

checking the emergency bag and signing it out for the day. I was also responsible for overseeing the handover from the night staff to the day staff. I was responsible for writing the staffing detail so I would decide which staff were detailed to which activities in healthcare that day and would co-ordinate the day's regime. There would have been around 4-5 nurses or officers on the landing as well as the doctor on duty.

Healthcare regime

44. In 2001 the daily routine in healthcare would start with the morning handover from the night shift. This involved the night staff reading out the care plans for each prisoner and giving a further verbal handover of any other more general observations about them. I would read out the relevant entries in the Observation Book during this handover and would alert staff to any entries of concern in the F2052SHs, for example if a prisoner had been crying all night or banging his head or was discovered to have been making a noose.

45. After the handover was completed, I would organise the detail for the day. We would then go and unlock the prisoners in the healthcare cells. We would carry out the daily cell clean with the help of those prisoners who were well enough. Then we would take the prisoners out for exercise. The rest of the morning would be taken up by association, where prisoners could interact with staff and other inmates and watch TV or play pool. During this period I would organise lunch. After lunch the prisoners would be locked in their cells during the patrol period. They would then be unlocked again to take part in association before dinner and the evening lock up.

46. There was quite a lot of time out of cell in healthcare, most of which was spent on association. We were keen to help the prisoners use this time productively. Officer Richards managed to get a workshop up and running at one point where those prisoners who were well enough could get involved in some light work.

D's attempt

47. I do not remember very much about D. He was quite demanding from what I remember being told by the officers and nurses at the time. That said, I had not really had a lot of contact with him as I had been on leave over the Christmas period. He was quite young, only 21 years old at the time. He was only just the right age to be in an adult prison so we put a lot of emphasis on keeping an eye on him.

48. The entries in the Observation Book on 27 December 2001 are now produced and shown to me as **exhibit PH4**. The Observation Book entries show that the 27 December was a busy day. The atmosphere in the healthcare centre was usually quite chaotic, due to the nature of the prisoners. The entries show that we had an adequate complement of staff, as we were able to run association. The entries show that on the morning of D's attempt, we had found medication, razors and a noose in the healthcare cells during the 09.00 locks bolts and bars check, now known as the cell fabric check. I did not write this entry. Unfortunately, it does not explain which inmates' cells these items were found in or what action was taken. I am afraid that I do not remember this incident at all. However, normally this kind of discovery would have been reported to the senior nurse or officer in charge of the landing. The inmates' F2052SH, IMRs and care plans would have been updated to say that a noose and a razor had been discovered in the prisoner's cell. If an inmate who was not previously on an open F2052SH had been found

with a noose in his cell, a form would immediately be opened for him. The standard follow up action would be for the inmate to be seen by the doctor when he came on duty. There is no mention of D in this entry and there is no note of the follow up action taken in relation to the inmates who had been found with these items in their cell.

49. During the morning of 27 December, we had put one inmate on report for theft, had put another inmate on report for abusing and spitting at staff and a further inmate on report for assaulting a nurse by throwing one of the pool balls from the pool table at her during association. This was quite a serious incident and I believe that due to the extent of the injury she sustained she subsequently needed to take sick leave. During the course of this morning, we had also transferred one inmate to an anti suicide cell, AS4.

50. The Observation Book shows that during the morning, D had smashed up his locker as he said that he *'couldn't stand being banged up any longer'*. Unfortunately, I do not now remember this incident clearly and cannot recollect what I knew at that time about the earlier incidents involving D in December 2001. I am sure that I would have been familiar with the entries in D's F2052SH and in the Observation Book at that time, as he had been on an open F2052SH for some time.

51. I remember Officer Leane coming to ask me if D could have a phone call. We thought that D might be calmer if he could speak to his girlfriend and so I agreed that he should have the phone call. We often find that by making this kind of gesture, we are able to diffuse potentially difficult situations. I honestly cannot remember why we made this judgment call. I wrote *'no further action'* next to the entry in the Observation Book as we did not think that any discipline action, such

as putting him on report or moving him to another location would be appropriate, even though he had destroyed prison property. Any medical decisions that were made would have been documented in D's care plan or on his F2052SH. I understand that neither of these documents is available.

52. When Officer Leane came back to the healthcare landing with D after the phone call, he walked back past the office where I was working. I remember D being quite upset. Once D had been locked up, Officer Leane came to see me in the office. Officer Leane told me that we should watch out for D because he was upset that his child was being taken into care. I then made a note of this in the Observation Book and on his F2052SH.

53. I do not think that I would have had time to consider whether to increase D's observations, as to the best of my recollection, the alarm was raised just as I had finished updating D's F2052SH and the entry in the Observation Book. I have in the past increased the observation level to constant without reference to a doctor. I can only assume that I would have discussed increasing the level of observations needed with D and then consulted the doctor when he next did his rounds. I cannot now remember at what time the doctor would have done his rounds on 27 December 2001, but should imagine that it would have been at around 09.30 when he started his shift and then at some point during the course of the afternoon. The timing of the rounds would of course be dependant on what other duties and urgent calls he had to attend to.

54. I told Officer Leane that we all needed to keep an eye on D and would have asked him to go and tell the staff. As far as I can remember he was in the office with me whilst I was making entries to this effect in to D's F2052SH and the Observation Book and so would have been with me when the alarm was raised. I

am afraid that I cannot now remember whether it was the agency nurse who shouted for help or whether someone blew a whistle to attract attention. The office was very close to D's healthcare cell and couldn't have been more than 5 cells to the left of where I was sitting.

55. When I heard the alarm, I ran down to D's cell, which was just seconds away from the office. I saw D was suspended from the light fitting. I gained entry to the cell. Officers Murray and Richards were supporting D by his legs. Officer Leane and I got on to the bed and supported him from above. We tried to undo the sheet. I shouted for anti-ligature scissors and the emergency response kit bag. I cannot remember clearly now but I think a nurse came back and said that she could not find the scissors. I shouted that they were in the emergency response kit bag and so someone went and fetched the bag and threw it into the cell. This was kept in a cell which was only about 15 yards away so it was not long before it arrived. I had to get down from the bed to open the emergency response kit bag myself to find the anti ligature scissors. To be honest, I was annoyed that the bag had just been thrown into the cell and that no one had opened it and brought the scissors to us. However, in real terms I believe that this did not delay us for more than a few seconds.

56. We cut D down carefully and checked his airway. I assessed whether he was breathing and had a pulse and checked for signs of spinal trauma. Unfortunately, his breathing and pulse were absent at that time. We started resuscitation and I fitted him with an oropharyngeal airway. He accepted the airway. This was not a good sign as it meant that he had lost his gag reflex. We commenced CPR and then attached him to a defibrillator. This showed what is known as pulseless electrical activity ('PEA'), which meant that the defibrillator would not administer a shock. There can be a number of reasons for this. I believed that the defibrillator

showed this output because D had been asphyxiated. This meant was that the heart was electrically sound but that physically the heart had stopped beating. I knew that the electrical activity would soon fade unless we continued CPR. In fact the established protocol for PEA is to continue CPR and give the appropriate drugs. I did not want to intubate at this point, as this would have required administering drugs to temporarily paralyse the vocal chords. We continued to bag him and perform chest compressions. Whilst this was going on I was trying to gain venous access so that I could give him the appropriate drugs.

57. I now understand that some of the staff on the scene had left to attend to the prisoner in the cell next to D, who was saying that he was going to drown himself in his sink. Dr Khan was called to assist us. He looked in but I seem to remember that he then went to walk on. I suppose he thought that we looked like we were coping well and did not want to interfere. Governor Clark shouted for him to come back and help. I had just drawn up some adrenaline which I was going to give to D. I handed this to Dr Khan as I was still in the process of taping down the cannular that I had placed and so it was Dr Khan who actually injected a shot of adrenaline into D's heart. We continued to give D CPR and fitted him with a spinal collar to help maintain spinal mobilisation. When the air ambulance team arrived, they administered the paralysing drugs and intubated him. We then put D on to the spine board so that he could safely be transferred to the ambulance.

58. The Observation Book entry made by Officer Richards at 15.45 states that when D was transferred to hospital, he had a pulse and was breathing without aid, this undoubtedly was due to the professionalism of the EMRT. We really thought that he was going to make a full recovery. I went to visit D in hospital with Kay George 4-5 days later as we were concerned about him. He was lying on a hospital bed wearing an oxygen mask. We were very upset, as we had thought that he was

going to be fine. We really did the best that we could for D, I am just sorry that there was nothing more we could have done.

59. I was very proud of the way the EMRT responded that day. I do not think that the staff got the recognition or the support that they deserved. They were discipline officers who had successfully passed a specialist training programme and were willing to put their reputations on the line to provide advanced support at HMP Pentonville. Their loyalty was unquestionable and they really did save lives. The paramedics called to attend HMP Pentonville were genuinely surprised and impressed by our response team. A letter from the air ambulance team praising the EMRT's resuscitation of Mr Clark on 28 December is now produced and shown to me as **exhibit PH5**. I think that the team on duty that day also included myself and Officers Leane, Murray and Richards. A further letter from Governor Gareth Davies to the London Area Manager, Adrian Smith, is now produced and shown to me as **exhibit PH6**. This letter requests commendations for the members of the EMRT involved in D's resuscitation attempt. However, I never heard anything more about this and certainly no one received a commendation.

60. After we had resuscitated D, two members of prison staff had to go with him in the ambulance to hospital. The other members of the EMRT had to go back on duty, and were immediately called to assist with the incident in the cell next door to D's. In fact, in dealing with this second incident the EMRT had to restrain the prisoner as he had attempted to assault me. I think that it would have been helpful for the staff to have had a break after the incident so that we could discuss what had happened and come to terms with it as it was quite distressing for us.

Changes in operational methods, policy, practice or management arrangements to help prevent suicide and self-harm in Pentonville and other prisons

61. I cannot remember any changes in policies practices or procedures that were brought in as a result of Mir D's attempt. We only usually formulated action plans as a result of formal death in custody investigations.

62. In my opinion it is extremely difficult to prevent incidences of serious self-harm and suicide. Prison Officers deal with a very difficult and vulnerable population group and do their best to manage the risk of self-harm in the prison environment. However I do think that having a fully functioning emergency protocol and an appropriately trained EmRT is a sensible way of responding to serious incidents and that de-briefs are an essential means of assessing and improving performance.

63. I also feel that the post incident support networks for those involved in responding to suicides or incidents of serious self-harm should be reinforced so that the individual members of staff involved are given the time, space and counselling they need to enable them to fully cope with their experiences.

I believe the facts provided in this statement to be true.

Signed P. Hayward
Position MANAGER F
Date 29-6-07