

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 RICHARDS

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

1. I am a healthcare officer at Her Majesty's Prison Pentonville ('HMP Pentonville'). I can vaguely remember D as I was on duty in the Healthcare Centre on 27 December 2001 and was a member of the Emergency Medical Response Team ('EMRT') that resuscitated him. I am aware of the terms of the current investigation and I am happy to assist the Prisons and Probation Ombudsman in his investigations wherever possible.

Background and qualifications

2. I joined the Prison Service in 1996, after having spent two years working for Securicor escorting prisoners in the north London area from police stations, courts and prisons. I started my Prison Service career as a prison officer on C wing in 1996. I spent nearly 5 years there looking after vulnerable prisoners,

detoxification prisoners and segregated prisoners. In about October 2000, I joined the healthcare centre as a discipline officer. I became a healthcare officer on A wing in 2004. I am called a healthcare officer but I am not medically qualified. My current job involves assisting a nurse in carrying out clinical tasks such as taking blood pressure readings, giving out prescriptions and carrying out observations

Healthcare at HMP Pentonville in 2001

3. When I joined the Healthcare Centre, it was housed on R wing. This was a residential wing made up of five landings. R1 was for vulnerable, psychiatric prisoners, R2 was for the physically ill and R3 was offices and treatment rooms. I am not sure if we were using R4 and R5 at that time. When I joined the healthcare centre there were also 2 wards on the R1 landing and 1 ward on the R2 landing.

4. I liked the fact that the Healthcare Centre was on a normal wing as I thought we had a good amount of floor space, particularly on the R1 landing. This was set up so that the office was in the middle of the landing. The office had Perspex windows so that you could see what was going on on the landing. In the office there was a big white board with the names of all the patients, their condition and any observations. The R1 landing was quite big and it had a pool table and a football table. At the far end there was a television that the prisoners could observations.

Working culture in healthcare

5. The discipline officers went into healthcare to clean the place up and to implement, as far as possible, the same level of discipline that was seen in the rest of the prison. I got along with all of the staff in healthcare as I was always willing to learn new things and see new ways of working. However there were sometimes tensions between the nurses and the officers. I think that this started when the officers came in because the nurses had always had their own way of doing things and they did not like it when the officers came in and did things differently. For example, we had different ways of interacting with prisoners and different ways of record keeping. As far as the nurses were concerned, they were there to look after the sick, they were not there to engage in banter with the prisoners. I think that some of the nurses were not experienced in dealing with healthcare in a prison setting, and even those who had worked with psychiatric patients were a bit unsure about how to deal with prisoners with mental health problems. Some prisoners would respond better to the officers than they would to the nursing staff but some preferred the nurses.

6. I enjoyed my job but I felt that staff morale was sometimes quite low in 2001 and 2002. I think that we were quite short staffed at that time and it sometimes felt that there were not enough discipline officers to run healthcare smoothly. We also had quite a lot of agency nurses in those days. I always got on with the agency staff, but it could be hard work when you were on duty with them, as they did not have keys for the cells so you would have to escort them everywhere.

7. There were a lot of staff changes between 2000 and 2002. I felt that the prison had hired some excellent nurses during this time and it was upsetting when they resigned in 2002. I think that they left because they were frustrated that they were

not able to grow in their jobs because they would be sent somewhere different on every shift, and were just being slotted into the staffing detail wherever there was a gap.

8. With such frequent changes of staff and management, I felt that sometimes there was no one to turn to for support and advice. I also found that it meant that information about what was going on in meetings at HMP Pentonville did not always filter through to us. For example, I do not remember ever having been given feedback from the Suicide Prevention Committee meetings.
9. A new purpose built Healthcare Centre was opened in about 2005. It seems very light and bright but I do not really know what it is like, as I have not worked in healthcare much since I became a healthcare officer on A wing in 2004.

Healthcare regime

10. When I started my shift in the mornings we would have a meeting in the office. The F grade nurse or senior officer would give us a handover. This would be to pass on information from the night shift about anything that had happened, for example which patients had had problems the evening before or during the night. This way we were aware of anything we should be looking out for as we were working. I would also go and read the records of the prisoners that I interacted with during the course of my shift. This was good background information but I think that I got the most useful information about a prisoner's state from my own dealings with them and from information passed on verbally by staff on the landing.

11. The day would start with the Locks, Bolts and Bars check, known as the LBBS.

This was to make sure that all the fittings were intact, check that the toilets and the sinks were working and that the alarm bells and locks worked properly. We would report any broken or damaged items and then check the cells to make sure that there were no restricted items in them like razors or medication. We also used to confiscate a lot of sheets that had been ripped up. Prisoners often used ripped up sheets to make lines. These are like bags on strings, which prisoners on higher landings would lower out of their windows into the cells below. It was a way of transporting items between prisoners such as canteen, cigarettes and medication. We would often find things like this and would make a note of it in the observation book and report it to a senior officer. We would also make a note in the prisoner's Suicide Self-harm at Risk form ('F2052SH') if they were on an open form and speak to the nurses to remind them to be vigilant.

12. Once the fabric check was complete, those prisoners who were well enough would clean their cells. A party of paid prisoners would go into the cells of those who were too ill to clean for themselves. At about 08.30 or 9.00, after the cleaning had been done, we would unlock the prisoners for exercise and association. Prisoners would be locked up for lunch at 12.00. We would do a lunchtime patrol during this period. I would usually take my lunch between 12.30 and 13.30. When I came back on duty the prisoners would be unlocked for association during the afternoon before dinner and evening lock up. Prisoners could also attend education, or go to the gym during the day if they were well enough.

13. Even if we were too short staffed to get all the prisoners out together, the officers would go round and unlock the healthcare prisoners in groups of 1 or 2 so that they could have time out of cell and play pool. In some ways the prisoners

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enjoyed this more as they would get more individual attention. However, we could only do this if we had enough officers on duty to be able to unlock the prisoners.

14. In about 2001 we closed down one of the wards on the R1 landing. I was really keen on the idea of giving prisoners in healthcare more continuity in their regime. I helped to turn the ward into a workshop where prisoners could do some light work. It was just putting together jackets for medical records but it kept the prisoners occupied and was a good way for the prisoners to interact with each other. Unfortunately, not all staff were as enthusiastic about this workshop as I was. When I came back from my paternity leave in 2002, I found that it had been closed down, as there were insufficient officers to run it. So we changed the workshop into an association room with a television and some jigsaw puzzles in it. This would have been late 2001 or early 2002.

The Emergency Medical Response Team

15. I was part of the Emergency Medical Response Team ('EMRT') at HMP Pentonville. It was known as HOTEL 9 as this was the call sign that staff used to call us to an incident anywhere in the prison. I was trained up by Senior Officer Haywood along with the other discipline officers when we came to work on healthcare. He taught us how to deal with different emergency scenarios and how to find an airway, support a casualty and use the resuscitation equipment. This was really helpful to me and I think that it was the best bit of training that I ever had.

16. Two trained members of staff would be assigned to the EMRT at the morning handover. One of the two would be working where the bag and all the equipment was kept on the R1 landing. If the alarm was sounded, they would grab the

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equipment and attend the incident with any other trained staff or doctors in the area at the time.

17. We relied on Senior Officer Hayward and Prison Service Nurse Tony Smith to take the lead on EMRT, as they were the most qualified to deal with emergencies, but if neither of them were on duty, there would not always be a team in place at that time. We no longer run the same level of trauma response as the training was changed after the Primary Care Trust took over the running of healthcare at HMP Pentonville.

Training

18. The trauma training we received when I first joined healthcare was brilliant. I also did a Healthcare Assistance Course at the Royal Free Hospital in around 2001/2002. This was a ten week course that I fitted in around my shifts at the prison. It covered topics like how to read vital signs and take blood pressure readings as well as mental health awareness and Cardio Pulmonary Respiration ('CPR'). This was about how to use defibrillators, put in airways, read vital signs and recognise trauma and shock. I really wanted to qualify as a healthcare officer when I moved to the Healthcare Centre, but I understand that they are not offering this career path in the Prison Service anymore.

19. I would have had suicide awareness training when I joined the Prison Service. Unfortunately I cannot remember now what this training involved. There was refresher training available but I never got to go on this, as we were so busy in healthcare and there were not enough staff to cover my shifts. I did not think that I needed refresher training as such because to be honest, suicide awareness is something you pick up from your experience working on the job. You just have to

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look at the person in front of you and go with your gut feeling about how they are from your interactions with them and how they appear to you.

20. I think that good training is really important and I always apply for new courses when they come up. However, I do not think that there is any training that could have helped me deal with D's resuscitation any better than I did. Once you have received trauma training, you just go on to automatic pilot and do all that you can to try and save someone's life.

Identification, assessment and care of those at risk of suicide or self-harm

21. If we thought that a prisoner was at risk of suicide or self-harm, we would open an F2052SH. We did not often have to do this in healthcare, as most of the prisoners there were already on open forms, so usually I would just note my observations in the form. Any member of staff could open an F2052SH on the basis of a conversation they had had with the prisoner, his general mood or any other concerns that they had about the prisoner. I cannot now remember much about the detail of how these forms operated as they have been replaced by the Assessment, Care and Custody Teamwork ('ACCT') planning system.

22. I think that once an F2052SH had been opened, the prisoner would have to see a doctor within 24 hours so that they would be assessed. The doctor would decide where a prisoner should be located and what level of observations would keep him safe. They would also make the decisions about medication and whether the prisoner needed to see a specialist.

23. There were multi disciplinary F2052SH case conferences where the prisoner's care and management was discussed. I think that these took place after the form

had been open for 72 hours. I do not remember now whether I attended whilst I was in healthcare. However, if I felt that something needed to be considered in a case conference, I would give the information to a nurse who was attending. For example, I would give her the observation book in which the concerns of discipline officers were noted and ask that the issue be addressed. I do not remember getting any verbal feedback from these meetings and would have to find out what had happened by looking at the F2052SH and the Inmate Medical Record ('IMR').

24. If I was worried about a prisoner, I would tell a senior officer or a doctor. They would decide what location he should be in and what level of observations would keep him safe. If the prisoner was not already on an F2052SH, I would open one and then make a note of my concerns on that form and in the Observation Book as well.

25. In 2001, there was an 8 bed ward on the R1 landing which was known as the 'anti-suicide ward'. The patients in this ward would be constantly observed by a nurse or an officer. It was not so staff intensive as a one to one observations and helped to keep vulnerable patients safe but was very difficult to manage. We also had to be careful about the patients we put into these wards as if we got the mix wrong, some of the patients could take advantage of the most vulnerable and take their canteen or cigarettes. I was concerned that it was almost impossible to interact with such a large number of prisoners at the same time and so they were really just observed. I was frustrated that more was not being done to address the problem with this ward at that time, but I am pleased to say that we eventually got it closed down in the end. We put the prisoners into healthcare cells and turned the ward into a day centre. I cannot remember exactly when this happened but I think it would have been during 2002.

26. I think that we only had two AS cells in healthcare at that time. We also used to have a gated cell but I think that this was being used as a storage room in 2001. The so called AS -cells were mostly used for violent prisoners but also on occasion for those prisoners who were violent and thought to be at risk of self-harm. The gated cell was not well lit as there were no window bars and the windows made of clear glass bricks. There were no ligature points in these AS cells. The light fittings and the heating were behind panels in the ceiling. The cell was very basic to ensure that as far as possible the prisoner could not harm himself or members of staff.

27. We sometimes also put prisoners in these cells for an hour or so if we had to move them urgently. For example, this could happen if the prisoner was in one of the wards but was being disruptive there. We would put them into one of the anti suicide cells until we had found another healthcare cell for them. We would only really move someone into that cell for a short period of time, whilst they calmed down. If they were very violent we would try to get them moved into the segregation unit. If they were at risk of self-harm we would keep them there until they had calmed down enough to go back in to a cell. These moves would always have to be authorised by a senior officer or doctor and documented.

28. Prisoners in healthcare could talk through their problems with the staff on duty but they did not always want to do this. Listeners were also available at the prison. Listeners are other prisoners who are trained to provide support and counseling. If a prisoner wanted a Listener then I would go to the Centre. This is the part of the prison where prisoner movements are co-coordinated. I would find out who was available and where they were and go and find them. When a listener was genuinely needed, there would be no problem in finding one. Often,

however, I would need to assess whether or not a prisoner truly wanted or needed a listener as sometimes prisoners would just want to be abusive towards someone, or would just try to get cigarettes out of them.

29. Prisoners in healthcare also had access to the Samaritans phone. This was a mobile phone, which prisoners could use to call the Samaritans. I thought that this was a very good idea as it gave prisoners someone on the outside to talk to from the privacy of their cell.

Suicide and Self-harm at HMP Pentonville

30. I think that in general, suicide and self-harm is always going to be an issue in prisons because of the nature of the prison population. A lot of prisoners have drug or alcohol problems or are mentally ill. I have not worked in any other prison so I cannot compare HMP Pentonville with other prisons.

31. When I joined healthcare in 2001, it seemed that there were more cases of self-harm there than in the Segregation Unit where I worked before. When the discipline officers came in to healthcare, we tightened up the procedures so that each prisoner's kit would be searched when they were admitted to healthcare and dangerous items like razors were confiscated. We enforced the rule that razors would only be given to prisoners for 10 minutes a day for them to shave with under supervision. This way prisoners could not use the blades to self-harm with. We also changed the canteen system in healthcare to make it more like the one in place in the Segregation Unit. Instead of escorting prisoners to the prison shop, we started handing out canteen lists to all prisoners. This allowed us to make sure that if there were any bottles or cans in the prisoners' canteen. We would store these until the prisoner wanted them and then would pour them into

plastic glasses or on to plates so that they could not use the bottles and cans to self harm with. If an officer found a prisoner had purchased a can, they would pour the contents of a can into a cup.

32. I did not think that there were many acts of self-harm or attempted suicides which were as serious as D's and I was glad that such incidents were few and far between. However, there were cases of self-harm in healthcare, even after we cracked down on razors and cans. These were not serious attempts and would involve things like prisoners unpicking their stitches from previous acts of self-harm or pretending to hang themselves with their sheets or shoelaces. Sometimes in the ward prisoners would encourage each other to do these things for extra canteen or cigarettes. This was very disruptive for the prisoners and was distressing for the nurses and officers.

Record Keeping

33. Information about prisoners in healthcare would be written in the IMR and attached nurse's care plan. Notes would also be made on the F2052SH if a prisoner was on an open form and on documented observations sheets. There was also a summary of information about prisoners in healthcare on the board in the office on the R1 landing. However, as there was a high turnover of staff and a lot of agency staff I felt that it was difficult to maintain continuity. Each member of staff had their own way of recording observations and so I felt like it was difficult to stay organised. I found that there was a lack of continuity with regards to information about prisoners as different people were making different entries in the different documents. When I joined healthcare, I found that the nurses made most of their notes on to the care plans, including what medication the prisoner was on and what observations they were making about them. It was difficult to

read these as they used a lot of medical abbreviations. As there was not anywhere to write down general comments that was easily accessible, I suggested that we start an Observation Book, like the ones prison officers used on the wings. This idea was well received by the management at that time and was put into place by 2001.

34. Record keeping was a problem in healthcare at that time as there were lots of different bits of paper for each prisoner. The Observation Book was kept in the office on the R1 landing along with the open F2052SH and the patient's IMRs and care plans. The IMRs of all the other prisoners at Pentonville were kept in the records room on the R3 landing. As healthcare needed to get involved in all prisoner movements, we would often have to prepare about 100 sets of IMRs a day for prisoners going to a clinic or being transferred or taken to court by an escort. We found that IMRs would go missing the most, often because they had been taken out by a doctor or a nurse and had not been returned. This was frustrating as it took us time to track them down again, but it was quite rare for a set of records to disappear completely. I think that now we have got the Electronic Medical Information System ('EMIS') computer database, this will not be such a problem.

35. I was asked by Governor Bell to conduct a search for D's records in 2002. I found a lot of information then by searching in the records room of the prison. I think that this included things like D's healthcare admissions papers and maybe his IMR and entries from the Observation Book. I understand that these cannot now be located.

Observations

36. Everyone in healthcare was on 30 minute observations as a general rule. If we were worried about a prisoner and thought there was a risk he could seriously self-harm or be at risk of suicide we would tell a senior officer or a doctor. They would put him on to one of the three increased levels of observations. The first increased level was the irregular 15 minute observations. The next level was the irregular 15 minute documented observations and the highest level was the constant observations. I did not make these decisions myself, as we would often need to bring in agency nurses to carry constant observations out. That said, I do not think that people who needed higher levels of observations were put at risk because of this process because the doctors could move prisoners into the ward for constant observations if they needed to.

D's attempt

37. Extracts from the Observation Book from December 2001 are now produced and shown to me as **exhibit PR1**. It is fair to say that I do not remember very much about D after all of this time. I think that he was quite young and could be quite difficult if he did not get his own way. I do not remember if he was on an F2052SH, but he probably was as he was in healthcare. He would have had an IMR and a care plan but I cannot remember the details of these after all of this time.

38. I would talk to D when I was on duty and I never had any problems with him. I do not really remember talking about his personal life, it was more just about his immediate needs. I do remember him talking about his girlfriend but I do not remember him having talked about children. I remember that he had been in the

ward but was moved out because he was taking advantage of some of the other patients in there.

39. Looking at these entries, it seems that D was trying to get medication from the doctors and officers in early December. It was sometimes difficult to tell whether a prisoner really needed medication or was trying to get drugs to take recreationally or to exchange with another prisoner for cigarettes or canteen. Prisoners talk to each other about what symptoms you need to say you have to get certain drugs and what effect the drugs will have.

40. I do not remember any of D's previous acts of serious self harm, but that is simply a lack of recollection. It is possible that I was not working in that part of healthcare in early December 2001, as I was sometimes in the ward on the R1 landing and was sometimes doing one to one observations.

41. On the 27 December 2001, someone alerted staff to D's cell. I think it was an agency nurse who shouted to alert me that there was a problem. I cannot remember where I had been or what I had been doing previously but when I heard the agency nurse shout, I had been standing in front of the gated cell in healthcare. It would have taken me only a few seconds to get from the gated cell to D's cell. When I got to the cell, I looked through the observation panel. I saw D hanging suspended from the light fitting. I was the first person to arrive with keys, as agency nurses do not carry these. I unlocked the door and rushed into the cell. He had torn the hem from his sheet to make the ligature and had slipped this underneath the light fitting. This would have been quite easy for him to do, as there was quite often a gap between the metal casing on the light fitting and the

ceiling. It would probably only have taken a few seconds to slip the sheet underneath the light fitting and knot it around his neck.

42. I went up to D and hoisted him up by the waist to take the weight off the ligature.

I also tried to get my hand up to support his neck and head. It was at this point that he urinated on me. This is not an uncommon reaction to the trauma. Officers Leane and Murray and Senior Officer Hayward arrived very quickly. They came into the cell and Officer Murray helped me lift D whilst Officer Leane and Senior Officer Hayward got onto the bed to try and undo the noose. The trauma bag was thrown into the cell at some point. A pair of anti ligature scissors was always kept in this bag. I could not see what Officer Leane and Senior Officer Hayward were doing or how they did it, but they managed to cut D down. I do not recollect there being significant delays. We lowered him onto the floor of the cell. He was not breathing and we could not find a pulse. Senior Officer Hayward was trying to find an airway and keep his head still.

43. Senior Officer Hayward got an airway in and then used an ambu bag attached to an oxygen cylinder to help D to breathe. I think that it was Officer Murray who started the chest compressions. I had the defibrillator next to me and I started to set it up. I put the pads on to D but we could not fire it up because D was not showing any pulse activity. So we kept the compressions going and continued to breath for him. I do not think we put a line in. We continued to work on him and tried to get his heart and breathing going until the ambulances came. I remember this clearly, as it was the first resuscitation that I had been involved in where the air ambulance came to the prison.

44. There was a lot of commotion on the R1 landing, which I discovered afterwards was because the prisoner in the cell next to D was also threatening to commit suicide. I cannot remember now whether the Doctor was present while we were resuscitating D.

45. The ambulance crew arrived and Senior Officer Haywood gave them all the details of the incident. We moved D out of the cell, as there was not enough space for them in the cell. We put him on a spine board and laid him on the pool table on the R1 landing. Lines were put in and he was given a shot of adrenaline to stimulate his heart. D started to come around. He was coughing and trying to remove his airway. We thought this was a really good sign. The ambulance crew anaesthetised D and Officer Murray and Officer Leane went off to the hospital with him.

46. Senior Officer Haywood went off with one of the Governors. I cleared up the cell as there were bits of trauma equipment scattered all over the place. We had a dispensation that allowed us to remove this before Security sealed the cell as we only had the one set of equipment. I put all the trauma equipment back into the clinic room on the R1 landing and made a note of the incident in the Observation Book. It was at this time that I read about D's phonecall. I completed an incident report but as I was the only officer left on the R1 landing, I just got on with my shift, even though my uniform was still wet. I was called to another emergency by one of the nurses not soon after. This was the inmate in the cell next to D. I attended with Senior Officer Haywood. I remember this incident too because we had to restrain the prisoner as he hit Senior Officer Hayward.

47. I felt a bit abandoned after the incident. No one came to ask if I was all right and I do not remember being offered any counseling or anything like that. I would have finished my shift at either 18.00 or 21.00. I cannot remember being on duty the following day and think I may have taken leave over New Year. No one contacted me to see whether or not I was all right over that weekend. When I came back to work the incident was not mentioned again until Carole Draper asked to interview me. It was only then that I was told about D's condition. I was very frustrated when I gave this interview and I complained a lot as it was the first real opportunity I had had to discuss my general experiences in healthcare with anyone and the memories of that day all came back to me.

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

48. I believe that a greater amount of discipline officers in healthcare would have further minimised self-harm rates in 2001, as it would have improved the interaction with prisoners and the regime in healthcare. I cannot really comment on what changes should be made now as I am based on A wing. In general though, I think that it is not realistic to put prisoners in so called strip cells to keep them safe. All that you can do is provide as safe an environment as possible and have a large group of experienced and skilled staff who are trained to interact and engage with prisoners and respond to emergencies if they need to.

I believe the facts provided in this statement to be true

Signed Paul

Position HCO

Date 28/6/07