1 IN THE MATTER OF A PUBLIC INVESTIGATION
CONDUCTED BY THE PRISONS AND PROBATION OMBUDSMAN
2 INTO THE ATTEMPTED SUICIDE OF LD ON 27 DECEMBER 2001
AT HMP PENTONVILLE
3

4 STEPHEN SHAW PRISONS AND PROBATION OMBUDSMAN

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7 MR KEITH MORTON (instructed by Treasury Solicitor, Laurance
O'Dea) appeared as Counsel to the Inquiry
8

9 MS KRISTINA STERN (instructed by Bindman & Partners, Saimo
Chahal) appeared as Counsel for LD
10

11 MR JAMES EADIE (instructed by Treasury Solicitor, Dilnaaz
Kazi) appeared as Counsel for the Prison Service
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14 Day 6 - Tuesday, 20th November 2007

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1 Tuesday, 20th November 2007

2 (10.30 am)

3 (Proceedings delayed)

4 (10.40 am)

5 THE CHAIRMAN: Good morning, ladies and gentlemen. I think

6 we must sensibly make a start now at 10.40, and good

7 morning to Dr Ranaweera, and thank you very much for

8 joining us. You sat through, I think all of yesterday's

9 evidence, so I think you are familiar with the way in

10 which the proceedings are conducted. I should perhaps

11 just remind you that in referring to the man at the

12 centre of the investigation, if you could try to refer

13 to him by his initial D, rather than by his full name,

14 that would be a kindness to the inquiry and indeed to

15 those who are responsible for preparing the transcript.

16 But anyway, thank you very much for joining us today

17 and my colleague Mr Morton will begin by asking you some

18 questions.

19

20 DR VASANTHA RANAWEERA (called)

21 Questioned by MR MORTON

22 MR MORTON: Dr Ranaweera, good morning.

23 A. Good morning.

24 Q. May I start by identifying your previous statements in

25 relation to the matters that we are concerned with.

1 First of all, I think in bundle 2 if you could be shown
2 that, please, at page 347, there is a transcript of an
3 interview that you had with the
4 Prison and Probation Service ombudsman on
5 22nd September 2006?
6 A. Yes.
7 Q. Then more recently on 7th November this year, there is
8 a statement in bundle 13, tab 3, which you prepared for
9 the Treasury Solicitor.
10 A. Yes.
11 Q. Have you had an opportunity to read both of those, the
12 interview and the statement recently?
13 A. Yes.
14 Q. Are you satisfied that the contents are accurate?
15 A. Yes, I think so, yes.
16 Q. You are satisfied that they are accurate?
17 A. Yes. The only thing is that both interviews were taking
18 place about six years after the incident, and as I have
19 told in both, in both reports, I can't remember a deal
20 because it was the first time I was interviewed after
21 five years last September and again this year. So
22 I can't remember him or what were the incidents, and
23 especially I have not got the IMR or inmate medical
24 reports or the 2052 which would have contained all the
25 clinical details about him, not available. So because

1 of that, I'm limited of what I can tell about what was
2 the care he had during that time.
3 Q. Absolutely, Dr Ranaweera, and I'm sure everybody
4 understands the disadvantage that that creates. But we
5 will do our best to see whether we can help jog your
6 memory, and if we can, we can and if we cannot, we
7 cannot, but we will press on, with that caveat we will.
8 You very helpfully set out in your most recent
9 witness statement for the Treasury Solicitor your
10 qualifications and experience?
11 A. Yes.
12 Q. Thank you for that, and I'm not going to take you
13 through them all. It is apparent that earlier on in
14 your career, you had some experience of working on
15 psychiatric wards, I think?
16 A. Yes.
17 Q. But is it, have I got this right, that you don't have
18 any qualification in psychiatry?
19 A. No, I have not got any post-graduate qualification in
20 psychiatry, I have a post-graduate qualification in
21 general practice, the GP, not in psychiatry.
22 Q. You do, however, refer to a particular course that you
23 undertook at St George's, I think, in relation to
24 detoxification and addiction?
25 A. Yes.

1 MR EADIE: I know that Dr Ranaweera has a copy of her own
2 statement and I'm sure no one would mind if you had your
3 own copy in front of you, particularly as I am sure that
4 Keith will be putting bits and pieces from it to you.
5 A. St George's hospital, as Dr Yisa mentioned yesterday, he
6 is the one who organised for all the prison medical
7 officers at Pentonville to attend that diploma course in
8 drug and addictive behaviour, at St George's medical
9 school in Tooting; and I was fortunate, I joined in 1996
10 and I was able to attend the end of that year. It is
11 a one-year course, once a week attendance, so I managed
12 to complete that, yes.
13 MR MORTON: It may be obvious to you, but that is a course
14 that has, or learning that has particular relevance,
15 does it?
16 A. Of course, yes.
17 Q. To work you were undertaking in prison?
18 A. Prisons, drug and alcohol, dual diagnosis, a very
19 helpful course, yes.
20 Q. Again, perhaps obvious to you, but in your experience,
21 is it common to come across inmates who have drug or
22 alcohol or addiction problems?
23 A. Of course, yes, it is about 60 or 70 per cent or
24 80 per cent have drug and alcohol-related problems.
25 Because Pentonville is a local remand prison, we come

1 across many people, young people, I mean younger.
2 Q. That was true in 2001 as it is today, is it?
3 A. Yes, I don't think it has changed much.
4 Q. I want to ask you, please, about the systems that were
5 in place in 2001, as best you can take your mind back to
6 2001 and in particular the end of 2001 for dealing with
7 new inmates on reception?
8 A. Yes.
9 Q. As I understand it from your statement, but please tell
10 me if I have this wrong, every inmate on reception
11 undergoes an initial screening process which appears to
12 be undertaken by a nurse?
13 A. Yes.
14 Q. Is that correct?
15 A. A nurse or a health care officer, from the
16 health care centre, either the health care officer or
17 a nurse and they do the first screening after assessed
18 by the discipline officers in the reception, for the
19 security and everything, and then he will be screened by
20 the reception doctor, usually a GP.
21 Q. That was my next question, so everybody on reception is
22 seen first by a health care officer or a nurse?
23 A. A nurse, yes.
24 Q. And then by a doctor?
25 A. Yes, all in the sense all new receptions or returns, not

1 all the returns will be seen by the doctor, obviously,
2 unless they have a change of status or if there is
3 anything of concern from the Securicor, you know with
4 self harm or any incidents, or change of status. They
5 go to court, they are given about a longer sentence or
6 something changed, in that case they will be put in
7 front of the nurses and they will be seen --
8 THE CHAIRMAN: You will be seen by the nurse on the evening
9 you were received?
10 A. The same evening, yes.
11 THE CHAIRMAN: And the doctor?
12 A. He is at the reception, in the reception area, the nurse
13 will screen after assessment by the discipline officers
14 in the reception and then all these inmates will be
15 assessed by the reception doctor. It is a very busy
16 place.
17 THE CHAIRMAN: On the same evening?
18 A. On the same evening, yes. Sometimes if they come late
19 or circumstances, they may end up like overflow, the
20 next day they have to make sure that they will be
21 assisted by the doctor, but most of the time they try to
22 finish it on the same day.
23 THE CHAIRMAN: Thank you.
24 MR MORTON: One of the functions of that initial screening
25 process is to decide where the new inmate should be

1 located; is that right?

2 A. Yes, because there was the form which the nurses, they

3 have to fill, the reception screening form. It has

4 changed now, but those days they use in all the prisons

5 the same form and it says -- the reception screening is

6 done by the nurses. They have to ask about whether

7 there is any physical problems in the past, mental

8 health problems, drug and alcohol problem, any

9 self harm; so everything, they screen everything and

10 depending on that, when they go to the doctor, it is the

11 same sort of questions they will ask, depending on what

12 are the relevant things.

13 Then the doctor will decide, depending on the

14 physical health problem or mental health problem, drug

15 and alcohol problem, whether they need to go to the

16 ordinary location that is the normal prison wings; or if

17 they have to go to the detox unit for the drug and

18 alcohol problem; or if they are mentally ill or quite

19 a lot of physical health, which they need inpatient

20 care, to go to the health care centre.

21 Q. That is an initial decision made on arrival?

22 A. Yes.

23 Q. If somebody is located in the health care centre?

24 A. Yes.

25 Q. As I understand your statement, they will then be seen

1 again by, sorry, they will then be seen by another
2 doctor?
3 A. Yes.
4 Q. Either on arrival in the health care centre or within
5 a relatively short time of arrival in the
6 health care centre?
7 A. Yes, because usually the reception start in the evening,
8 because the courts, they are busy during the daytime,
9 and they started coming usually after 5 o'clock onwards,
10 after 5 o'clock, sometimes they can come during the
11 daytime, not very -- mainly they come after 5 o'clock.
12 Then when they -- assessed by the doctor, the reception
13 doctor, there is a form for them to complete, whatever
14 the findings, and then in the continuation sheet in the
15 IMR, they use the continuation sheet where to write, you
16 know, they write their thing: admit to
17 health care centre, what sort of medication to be given;
18 if there is any alcohol problem, they give the detox as
19 well.
20 So they write all the plan in the IMR and then when
21 you go to the health care centre, I'm talking about the
22 inpatients now, so if you need the health care
23 admission, the inmate will go with the IMR; he will be
24 taken to the health care centre, so the nurse on duty
25 there, they will find out what the doctor had written,

1 why he was admitted, and accordingly the nurses will
2 write their care plans and carry out the management plan
3 according to the doctor's advise at the reception.
4 Q. Pausing there. Are you saying that the doctor on
5 reception drafts a management plan?
6 A. Yes, because --
7 Q. So that is before the doctor in the health care centre?
8 A. Of course, because --
9 Q. Has seen him?
10 A. Yes, because mainly the admissions from the reception,
11 they normally come in the evening as I told you. The
12 reception start normally after 5 o'clock and until,
13 usually the duty of the doctor, the daytime, normally
14 from 9.00 am to 5.00 pm, so there is no doctor presiding
15 in the health care centre after 5 o'clock, unless they
16 are late doing their own work, which normally we have to
17 wait and finish our work, otherwise there is no doctor,
18 the same reception doctor after 5 o'clock on call for
19 the prison nurse if there is any emergency.
20 So there is no doctor in the health care in the
21 evening, so the nurses have to carry out the plan. It
22 is a short plan, they are not going to do it in detail,
23 because there are about 20 new patients coming in the
24 reception, so they will not have to write detail but --
25 until they are seen by the doctor, they will write the

1 care plan.
2 Q. A patient is going to arrive on the health care centre
3 already with an IMR which will include a management
4 plan?
5 A. Yes.
6 Q. Or an initial management plan?
7 A. An initial management plan, yes.
8 Q. They will be seen by a nurse?
9 A. Yes.
10 Q. Who will prepare a nursing plan?
11 A. Yes, they will write whatever the management, what he
12 needs, and then the treatment card will be written by
13 the doctor as well. So that IMR and the treatment card
14 will go with the inmate to the health care centre, and
15 the nurses will carry out, they will read what the
16 doctors have written and according to the plan they will
17 write and carry out the treatment, what was the
18 medication according to the prescription.
19 Q. Then within a short time of arrival in the
20 health care centre, it may be the following morning or
21 perhaps if it is a weekend, it will be on the Monday,
22 the new arrival will be seen by a doctor on the
23 health care wing; is that right?
24 A. Yes, so during those days, I mean the bundles I got last
25 week, four big folders to read, one of them, I found

1 this one for the first time, this is the admission when
2 they are in the health care centre, we had a thing
3 called admission book, the nurses or whatever is in
4 charge, they are supposed to write the names of the
5 inmates come in the evening or whatever the day, they
6 have to write in the admission book which was located in
7 the nurses' station and I found this in the bundle at
8 this point.
9 Q. Is that one of the documents exhibited to --
10 A. The documents under the observation book documents, you
11 know that one.
12 Q. Is it one of the documents exhibited to your statement
13 that you are referring to?
14 A. I think it is at tab B.
15 MR EADIE: The back of tab 5 in bundle 1, page 74-75.
16 A. It is a diary, you know. We normally keep a diary for
17 the year, so we know exactly what day they have come.
18 MR MORTON: Is this an extract from your diary?
19 A. Not my diary. We always carry our diary to write about
20 things. This is the one what we called admission,
21 admission book, actually it is a diary, year's diary, so
22 on whatever the day they come, they enter each year, we
23 had the admission book.
24 Q. Obviously this relates to Mr D?
25 A. That is why they have put these two in the folder.

1 Q. This is a diary kept in the health care centre.
2 A. Health care centre, in the nurses' station, so if the
3 inmate comes either from the reception or from the main
4 wings, any admission, they are supposed to write the
5 names in this book, so that means the doctor who is on
6 take for the day knows how many admissions there.
7 Sometimes they forget to write the names, but in here
8 usually they write in this book, so that means the
9 doctor will know how many admissions, where they are and
10 then you will look for the IMR and discuss with the
11 nurses and by looking at this, I don't know whether you
12 want to discuss this later or you want me to --
13 Q. What I'm trying to do at the moment is to understand
14 what the system was and we will come to this in a moment
15 if I may.
16 A. Yes.
17 Q. The doctor who sees the new inmate on the health care
18 wing --
19 A. The wing, yes.
20 Q. -- within either the following day or the following
21 Monday, if it is a weekend, does that doctor
22 automatically become the allocated doctor, so to speak,
23 for that inmate?
24 A. Yes, so what happened after 5 o'clock on Friday --
25 Q. Is that correct?

1 A. Allocated doctor, yes.
2 Q. Sorry, I interrupted you.
3 A. Friday afternoon, there is a weekend cover, the on-call
4 doctor, so that doesn't mean when the patient comes
5 after 5 o'clock Friday they don't have any doctor.
6 There is a doctored for the weekend so if there is
7 any -- if they wanted for any reason for the inmate to
8 be seen by the doctor, they will ask who are the nursing
9 staff in the health care, they will ask the on-call
10 doctor who comes on Saturday and Sunday to attend to.
11 But the detailed assessment will be done by the regular
12 doctors who come on Monday morning like in this case.
13 Q. You describe that process of the detailed assessment in
14 your statement as clerking?
15 A. Yes, clerking, yes.
16 Q. The new person?
17 A. Yes, like in the hospital we call it clerking, yes.
18 Q. That is a comprehensive assessment, is it?
19 A. Yes.
20 Q. Or as comprehensive as you can manage?
21 A. Yes, because --
22 Q. With that new person?
23 A. Yes.
24 Q. On average, if you can answer this question, how long
25 does that take?

1 A. Depending on the patient, how co-operative and a lot of
2 factors, maybe at least about an hour, it will be even
3 more maybe than an hour, because you have seen the
4 inmate, you have to do the assessment, there is quite
5 a lot of other things to do, like talking to the inmate;
6 we have to find out about the -- normally we take why
7 they are here, we want to know what sort of offence,
8 because if it is like nature of charge, it is important
9 that they have to be seen by which psychiatrist to see,
10 so the nature of charge is important. Whether they have
11 been in the prisons before, background, we need to find
12 out about the social background they are coming from and
13 the social circumstances, not very detailed, but we need
14 to see what sort of circumstances coming, what sort of
15 problem they have. Past medical problems, past
16 psychiatric problems and any drug or alcohol related
17 problems, and the previous convictions.
18 When you talk to the psychiatrist, it is important
19 to find out whether he has been under the psychiatrist,
20 which hospital admissions, and so we get all the detail.
21 One thing we go through the reception screening very
22 important by the nurses and the doctor, and sometimes
23 from the court the warrant comes, the copy of the
24 warrant will be there. Sometimes they may ask for
25 a psychiatric report and when they have to go back to

1 court, and why they have been remanded in the prison.

2 Q. From a medical or clinical point of view, you are doing

3 more presumably than simply taking a history; you are

4 making an assessment?

5 A. No, we had to go into detail, I mean in Pentonville

6 prison, I don't know about the other prisons, but

7 Dr Yisa was very particular about inpatients. We had to

8 do clerking like in the hospital. We used to do pages

9 and pages, three or four pages clerking.

10 Q. Forgive me, the history is obviously very important and

11 keeping a record of it is very important, but having

12 taken that history, presumably you are then making an

13 assessment about their health care?

14 A. We have to do the physical assessment, yes. We have to

15 do the physical assessment, whether they have mental

16 health problem, we do a physical assessment as well,

17 blood pressure, pulse, a physical examination; and also

18 the mental health, mental state assessment we have to

19 do; whether they are -- what sort of -- if they are

20 depressed or self harm risk or psychotic or mentally

21 ill, so we need to do assessment and then we write our

22 diagnosis, provisional but with a diagnosis, and my

23 plan, what is the plan for the patient.

24 Q. I wanted to ask you about that, because you have got

25 already at this stage an initial management plan from

1 the doctor on reception?
2 A. Yes.
3 Q. But you have now in general terms, you have undertaken
4 --
5 A. A detailed.
6 Q. -- a detailed assessment, which presumably results in
7 a new or amended management plan?
8 A. Of course, yes, yes.
9 Q. Where is that management plan recorded; is that in the
10 IMR?
11 A. Yes, the IMR, all this what I told you is entered in the
12 inmate medical record, like in the hospital.
13 Q. So the doctor's management plan is to be found in the
14 IMR?
15 A. The IMR, yes.
16 Q. The nurses have already prepared their initial care
17 plan. Might that come to be altered or amended in the
18 light of --
19 A. Of course, yes. When they come to the inpatients,
20 especially why they have come to the inpatient, they
21 have some medical or mental health problems. That is
22 why we need a full assessment, a detailed assessment,
23 and my assessment, physical, it doesn't stop there. We
24 need to get the collateral information either from the
25 GP or from the hospitals, so there is a form called

1 an 1104. That means the inmate gives their consent for
2 us to contact the outside services. Sometimes if they
3 are unco-operative, they can refuse. They say: no,
4 I don't want.
5 Q. As a matter of routine you would seek to obtain, would
6 you, material from the GP or from other hospitals?
7 A. Psychiatrists, previous.
8 Q. What about other existing prison inmate medical records,
9 if the person has been in prison before, either at
10 Pentonville or at another establishment, were you then
11 able to obtain medical records already prepared?
12 A. Yes. Some inmates have been in the prison several
13 times, sometimes they may have been in Pentonville
14 itself, so we have to ask for the old IMR. Sometimes
15 you get it in a few days, or sometimes you cannot find,
16 and you have to get it from the date records. If we
17 have the previous one it is very useful. They have been
18 seen by the psychiatrist and there is quite a lot of
19 information available, and sometimes from the other
20 prisons we can request, but it is time-consuming how
21 long it will take.
22 Q. As a matter of routine, you say it might have taken some
23 time, were you in fact generally able to obtain previous
24 inmate medical records or?
25 A. Yes.

1 Q. Or were there times when you couldn't get hold of them?
2 A. We could not get hold of -- even this one is missing,
3 sometimes to find the IMR is not that easy, because the
4 date record --
5 Q. You need to slow down a little.
6 A. Because once they are discharged from the prison, they
7 go to the date records, it is kept in the main prison;
8 and to find the IMR is not all that easy. We manage to
9 get some IMRs which is fine, quite helpful.
10 Q. In relation to existing medical records outside of the
11 Prison Service, presumably there is no avoiding the fact
12 that you are dependent upon what the inmate tells you
13 about where they have been treated previously?
14 A. Yes, because, yes, or sometimes they will have more
15 information in the IMR itself, you know, that they were
16 treated, like in the warrant sometimes we get, if they
17 are assessed by a court diversion scheme, sometimes the
18 inmates are already assessed by the court diversion
19 scheme, sometimes they come with the report, which is
20 very helpful.
21 THE CHAIRMAN: If it is clear that the prisoner has served
22 a previous sentence at another establishment, was it
23 routine in 2001 to request those previous medical
24 records?
25 A. Not routinely, so many times they come, they have been

1 at other prisons, but the relevant thing, whether he was
2 seen by a psychiatrist, those other things, not the
3 previous centre's detail, not routinely we ask; but if
4 they have any mental health issues, whether they were
5 seen by any psychiatrist, then we will go in the detail
6 of those accounts, yes.
7 MR MORTON: The purpose of there being an allocated doctor,
8 was that to ensure consistency of approach to the care
9 of that inmate?
10 A. The thing is, I mean, when it comes to the admission,
11 there must be something, who will see the patients,
12 because there are about two or three doctors working in
13 the health care in relation to their duties they are
14 given. So we need to know this. That is why they have
15 this allocated system. Earlier they were divided
16 admissions according to how many doctors and how many
17 patients, and then became for the day allocated doctors,
18 so that person wants the detail about the patient, they
19 are aware of --
20 Q. I'm asking you about why there is an allocation?
21 A. The purpose is in that case, the doctor who had done
22 a full assessment, they know about the things and who to
23 contact and all the details, and also referring to the
24 psychiatrist, getting information is all done by the
25 same doctor.

1 Q. But thereafter, that doctor is the allocated doctor?
2 A. Yes.
3 Q. Does that mean they have any particular responsibility
4 towards the care of the patients that are allocated to
5 them?
6 A. Yes, because I mean in the health care, when they come
7 to the inpatient, it is a team work, you know, doctors,
8 nurses in the health care office, it is a team work what
9 we do. By having the one doctor, do the assessment
10 daily, they will be reviewed until they are discharged
11 from the health care centre, they will be under the same
12 doctor. So that means if the day-to-day events and
13 day-to-day care will be, you know, if the nurses want to
14 come and discuss with the doctor, they will come and
15 discuss with the same doctor. Unless the weekends or
16 the out of hours, yes.
17 Q. Presumably, that doctor sees the person thereafter
18 regularly. We will talk in a moment about the rounds
19 that were done?
20 A. Rounds, yes.
21 Q. Pretty much every day?
22 A. Almost depending on the day, like I mean during the
23 on-take, it can be really busy, depending on the time.
24 Otherwise even if you don't see them every day, in the
25 morning when we go to the health care centre, the first

1 thing we ask who is in charge, the nurse or the
2 health care officer, we ask about my patients when I go
3 down. Because there is a board in the
4 health care centre, nurses' office, all the names and
5 where is the location, so there were two landings, R1
6 and R2 and there is an observation ward as well. So we
7 go to each area and find out who are in charge from
8 them. Anything from the previous day, you know, whether
9 there is anything of concern --
10 Q. You are going too fast again. Slow down a little.
11 A. So we will ask about the update, about our patients,
12 each landing. So we will, if there is anything they are
13 very much concerned --
14 Q. So you would have a responsibility, would you, as an
15 allocated doctor, for monitoring and overseeing the
16 treatment and care of the patients that are allocated to
17 you throughout their time in the health care centre?
18 A. Yes, as I told you, it is not one person who is
19 responsibility for each patient, it is teamwork, but if
20 there is any day-to-day care and treatment-wise, and
21 yes --
22 Q. I was not suggesting that the allocated doctor is
23 responsible for all the treatment.
24 A. No, overall.
25 Q. I was asking you whether they had a responsibility

1 overall to ensure, or not to ensure, but to monitor the
2 treatment and care of their patients, or is that not
3 right?
4 A. I don't know whether you can call it monitor. As
5 a doctor I had to make sure if they are under a -- if I
6 am the allocated doctor, I have to make sure whether
7 they are -- if there is any -- about the care they are
8 getting, they are getting the care what they needed to
9 be -- why they are in the health care, they are getting
10 the correct treatment; if there is any self harm or
11 something we have looked into, and discuss with the
12 nurses day-to-day the care management, yes.
13 Q. A slightly different topic but still asking you in
14 general terms at the moment, you have got an inmate who
15 has been sent by reception to the health care centre and
16 within 24 or 48 hours, they are seen by the doctor who
17 undertakes the clerking process that we have been
18 talking about.
19 Do you at that stage also consider where within the
20 health care centre the inmate should be located or has
21 that decision already been taken?
22 A. From the reception, depending on the assessment from
23 there, they would have already allocated either ward 3;
24 if they are concerned about self harm, or something,
25 they may say ward 3 or some sort of observation level,

1 the doctor would have already written in their plan.

2 Q. Please slow down.

3 A. Sorry, so when, following the assessment, depending on

4 the assessment's findings, you know, you may have to

5 change the level of observation and the way to locate as

6 well.

7 Q. So the options for location within the

8 health care centre, have I got this right, in December

9 2001, as best you can remember, ward 3?

10 A. Yes.

11 Q. Single cells?

12 A. Yes.

13 Q. Or the AS cells, anti suicide cells?

14 A. Yes.

15 Q. We will talk about each of them in a moment. Were those

16 the three options that were available to you within the

17 health care centre, or was there anything else?

18 A. There was some -- I mean, there were two landings. It

19 is not a properly -- hospital, you know, purposely built

20 hospital. It is a very old prison wing which was

21 converted temporarily as a health care centre and there

22 was some landing, R1, the bottom one, mainly for the

23 mentally ill, or disturbed patients in R1; and in the

24 R2, usually mostly for the physical, that doesn't mean

25 the mental health problem people also to be seen there,

1 R2, the same landing on the other side, a dormitory
2 where there is an observation panel where the nurses can
3 see, about an eight-bedded observation ward.
4 In addition in R1 landing, there was some two
5 dormitory accommodations called ward 1 and ward 2, which
6 each one had about four beds, but which was closed,
7 I think during that time there was ward 1 and ward 2
8 were closed, and later, not during this time, I think
9 later, even the ward 3 was closed after some time.
10 Q. I think one of the points that Dr Yisa makes is that two
11 of the wards, I think two of the wards were closed and
12 we have heard from other evidence that they were either
13 going to be or had been converted into workshops and
14 such like?
15 A. Yes, for some time they were used as workshops, yes.
16 Q. Those were the options that you had, so for somebody who
17 was thought to be mentally unwell, the options became R1
18 landing, single cell, or ward 3 or the anti-suicide
19 cells; is that right?
20 A. R2 as well, in R2, there were mentally ill people in R2
21 landing as well, because in the health care, there is no
22 shared cells; it is all single cells or the dormitory.
23 Q. For somebody, again I'm just asking you in general terms
24 at the moment, I'm not asking you about Mr D, for
25 somebody who was thought to be at risk of self harm, was

1 there a preferred area to locate them, depending on
2 their -- or did it depend upon their risk or what; how
3 would you make a decision about that?
4 A. When it comes to self harm, we had to think about the
5 other inmates as well, whether he is a risk to himself
6 and a risk to the other patients as well as to the staff
7 as well. Because if there is no risk to the other
8 inmates, then the ward 3 will be the ideal one, because
9 there is observation panel, a nurse sitting there and
10 they can see through the glass panel what is the inmate
11 doing and they can interact with the other inmates as
12 well, which is quite a good thing; and also when they
13 had ward 1 and ward 2, it is dormitory accommodation
14 where they can interact with the other inmates which was
15 quite useful.
16 Q. If there is space available on the ward and if the
17 inmate is not thought to be a risk to others, but only
18 to himself?
19 A. Yes.
20 Q. The ideal place, is this right, to locate them would be
21 on the ward?
22 A. Yes, if there is -- because that is the observation and
23 interaction, quite a lot of things in one place, so it
24 would have been ideal, yes.
25 Q. In what circumstances would the anti-suicide cell have

1 been used?
2 A. Those are not routinely used for, because those are the
3 things which what you call the semi-furnished cell, they
4 have not got much facilities purposely to avoid
5 self harm, because if they have benches they can hang
6 themselves and so many items they can use as weapons for
7 self harm; so those are temporary measures, those cells
8 are used as temporary measures.
9 Q. But when?
10 A. They are very disturbed sometimes, you see many in the
11 health care centre going through all of this, like D
12 from time to time, you know very disturbed behaviour,
13 self harm and then to calm them down and also for the
14 observation level as well, so those were used.
15 Q. So if the risk was thought to be increased or
16 particularly high?
17 A. Yes.
18 Q. You might use those cells; is that right?
19 A. Yes. Self harm as well as for the risk for the other
20 people as well, yes.
21 Q. Asking you, if I may -- I'll start that again, if I can
22 ask you now about the single cells, if somebody was in
23 a single cell, would they automatically be under some
24 sort of observation, routine observation or not; might
25 you have some people in the health care centre in

1 a single cell, but not subject to observation?
2 A. In the health care, I don't say that there is not under
3 observation, because during that time routinely, because
4 I have been working there since 1996, and what they say,
5 whoever is admitted to health care, whether it is mental
6 health problem or physical health, it is called
7 15-minute supportive watch. That means when they come
8 to the health care, rather than the ordinary location,
9 they have more supervision by the health care staff,
10 whether nursing -- or the health care officers or the
11 staff, observation, than in the ordinary location, so it
12 is the 15 minutes supportive watch.
13 Q. That is really what I am asking you. If somebody is in
14 the health care centre in a single cell and I'm
15 concerned only with people with mental health issues,
16 would they always be subject to some sort of observation
17 routinely?
18 A. Yes.
19 Q. Whether it is the 15 minutes supported or documented?
20 A. 15 minutes supported watch for everybody, everybody
21 admitted to the health care, but if they are concerned
22 about the self harm risk, you know, if you have to
23 increase the level of observation, then we call this
24 15 minutes documented watch and for that particular
25 person somebody had to document every 15 minutes what

1 they are doing, so they have a more observation level
2 and a person, for that particular person.
3 THE CHAIRMAN: The distinction here is important; the
4 distinction is entirely one of the recording as opposed
5 to the nature of the interaction; both the supported and
6 the documented watch, you would expect the person
7 concerned, whether it be the nurse or the health care
8 officer, whoever it may be, to have the same engagement
9 with the patient.
10 A. Yes, because they will have the interaction and also by
11 having the recorded, when they have the recorded watch,
12 they will be, you know, they will have more interaction
13 I would say, every minute, 15 minutes, they record it as
14 well, so they will normally talk to that person, you
15 know, if there is concerns, because --
16 THE CHAIRMAN: I'm not quite sure I understand. Why do you
17 have more interaction if you have to record it?
18 A. More interaction in the sense, not everybody we put for
19 15 minutes recorded watch, I mean, whoever needs more
20 observations we put them on the 15 minutes recorded
21 watch, so that means one particular person had to be,
22 you know, do that work in addition to whatever the
23 health care, other nursing duties, you know.
24 THE CHAIRMAN: So in your view, the answer to my question is
25 that though one is described as a supported watch and

1 one is described as a documented watch, in fact there is
2 more support offered by a documented watch.
3 A. Yes, I will say, I mean, if there is any people, because
4 sometimes that is like why yesterday, the agency nurse,
5 they have about five or six, or several people on
6 15 minutes documented watch. The nursing staff on duty,
7 they cannot go on writing every 15 minutes, because they
8 have to engage with other work, so that is why they put
9 one particular person for that duty, so that means if
10 they have one particular person for that sort of duty,
11 they will have more time to interact with the inmate
12 than normal supportive watch.
13 MR MORTON: In your view, that is what should happen
14 presumably.
15 A. I think that is what usually, yes.
16 Q. You think generally that is what did happen?
17 A. Yes, like yesterday we heard that she was going and
18 talking -- sometimes the inmate, they don't want to talk
19 to the person.
20 Q. Since you raise it now, Dr Ranaweera, perhaps I can just
21 ask you about that. There are two points really. The
22 first is this: if the nurse who is dedicated to doing
23 those documented observations has to do that for each
24 inmate he or she is responsible for every 15 minutes,
25 and they have perhaps six inmates that they are

1 responsible for, that actually gives them a very short
2 space of time, doesn't it, to interact with any one of
3 them?
4 A. I don't know how the nurses allocate people, how many
5 people for, because from time to time --
6 Q. Just assume that the evidence that was heard yesterday
7 was right, that it was six or up to six?
8 A. That is what she said. The only thing is --
9 Q. I appreciate that is what she said, which is why I'm
10 asking you the question, does that surprise you or not,
11 that she might have been responsible for six inmates?
12 A. I think when they have, when they have the 15 minutes
13 recorded watch, I don't know how many people, whether
14 they have the -- in the regulation, how many people they
15 have to look after under the 15 minutes, whether it is
16 four or five or there is a limit, I don't know.
17 Q. Does six sound to you perfectly reasonable, acceptable,
18 what you would have expected, or does it surprise you?
19 Did you think: well I'm quite surprised at six, because
20 that doesn't give her very long. You tell us?
21 A. Depending on how many nurses on duty as well, because
22 I don't know how many usually the 15 minutes recorded,
23 because it is not something I will say: you must have
24 one 15 minutes, how many people need to be under the
25 15 minutes recorded watch.

1 Q. It doesn't necessarily depend on the number of nurses --
2 I see what you mean. But if you have got one nurse, who
3 is undertaking the 15-minute documented watch and has to
4 do that for six inmates, do you regard that as
5 satisfactory or not?
6 A. The thing is, if they don't do any other work, you know,
7 it is only looking after them, it would have been ideal.
8 If they have more nurses to interact it would be a good
9 idea but at the same time depending on how many people
10 they can afford to be on duty, because usually this sort
11 of thing they get from the agencies and they take some
12 time to get an agency nurse as well for this recorded
13 watch, and it is every day we review, you know the level
14 of observation.
15 Q. It is a straightforward question, Dr Ranaweera, with
16 respect. You had the agency nurse there on this
17 particular day, so the problems of actually getting
18 somebody in had passed and there were six inmates that
19 she was responsible for undertaking the 15-minute
20 documented observation on. Was this a satisfactory
21 arrangement in your view or not?
22 A. No, it would have been ideal to have more time to spend
23 with the inmates, you know, depending on what sort of
24 problems the inmates are facing, you know, it would have
25 been better to have some more time to spend with the

1 inmates.

2 Q. The second part of the question I wanted to ask you was

3 this. If an inmate simply doesn't, or chooses not to

4 interact with the nurse that is undertaking the

5 observation, either by saying: I don't want to talk, or

6 by turning away, or whatever; is that something which

7 should simply be accepted by the nurse and he or she

8 should move on, or should they try and interact, should

9 they exercise their professional skill and attempt to

10 interact with an inmate?

11 A. Of course, I mean, because depending on what sort of

12 mood the inmate, sometimes they may be, if they refuse,

13 that doesn't mean that you have to just ignore them for

14 the thing. No, you have to go and interact with them to

15 find out. Maybe there is a thing that they are worried

16 about, next minute they will be all right, like anybody

17 else. You don't have to be a prisoner. Sometimes you

18 don't feel like talking to somebody. You want your own

19 space.

20 Q. How did this operate in practice? I'm trying to get

21 a picture in my mind that you have got an inmate who

22 within every 15 minutes is going to have somebody coming

23 to them and trying to talk to them. Might that not just

24 become an irritation for the inmate?

25 A. Yes, it can be, as well, at the same time the whole

1 purpose of having the observation, we have to make sure
2 that the person is, that we are keeping him safe under
3 our care, so it is --
4 Q. This is a dilemma, isn't it, because on the one hand you
5 want to have a system that enables you to interact?
6 A. Yes.
7 Q. And you are saying that the nurse should make an effort
8 to interact. And on the other hand the system itself,
9 if it is happening every 15 minutes, may just be
10 counter-productive, might it, I don't know, you tell us?
11 A. It is not only 15 minutes. Even the one to one is
12 worse, somebody one to one all the time, but we have to
13 do that to safeguard the person, because sometimes,
14 depending on whatever the behaviour, the self harm, it
15 is more serious, it can have serious consequences. So
16 you have to judge which one you want; you want somebody
17 to just leave alone and have self harm and later regret
18 about that; or, I know it is interfering, that is what
19 even the person must be thinking, but we are doing it
20 with a good intention to help the person.
21 Q. What I'm coming to is this. In practice what in your
22 experience was actually happening? Were you satisfied
23 that the nurses were trying to interact, or did this
24 just become essentially a paper exercise of looking in,
25 seeing whether somebody was awake, asleep, standing up,

1 lying on the bed, making an entry in the log and moving
2 on?
3 A. I don't think it is a paper exercise. You are employing
4 somebody, the nursing staff or whoever on duty, they are
5 professionals and they have got experience caring for
6 the patients, so they know what exactly -- sometimes,
7 not only they don't want to talk to you, sometimes they
8 can be very abusive, you know, verbally abusive,
9 sometimes you can go in there and even they can throw
10 something, it can be, but it is part of our job, you
11 know, so we must know how to cope with the things and
12 try to help the person.
13 Q. All right. Can I move on, then, please.
14 I've already asked you about the management plan
15 that was prepared by the doctor and the care plan that
16 is prepared by the nurse. I meant to ask you, and
17 I don't think I did, how those two related to each
18 other? Would the doctor be aware of the nurse's plan
19 and the nurse aware of the management plan, and how did
20 that happen?
21 A. Usually once we do the clerking, and once I do my
22 management plan and normally not only writing, we
23 discuss with whoever is in charge of the, you know, the
24 landing, we will discuss about our problem, you know,
25 these are these other things, and at the same time they

1 often read our management plan and also we discuss with
2 them, we don't just read and write it and go away. We
3 discuss with them what are the admissions we see, about
4 our management plan and the nurses' care plan, we don't
5 go and read all the nurses' care plan. It is from the
6 formulation, they formulate what sort of care they need,
7 and they enter in their care plans.
8 Q. Which nurse was responsible for preparing a care plan in
9 relation to any particular patient? Was there a system
10 in place in December 2001 to ensure that that was done?
11 A. I can't exactly, tell exactly in 2001 what -- normally
12 what happened, I'll say, normally you see the patient,
13 whoever on duty at that time, the nurse is on duty at
14 that time and when we discuss then, they will be the one
15 who will be, who is responsible for doing the care plan.
16 Q. So was there for each inmate a nurse who was principally
17 responsible for their nursing care or not?
18 A. For each patient, when we see the patient, I don't know
19 whether each inmate had one particular nurse all
20 throughout, because they are changing shifts and
21 everything as well, but whoever is on duty at that time,
22 they had to write the care plans, not per person, so
23 I don't know how many people, depending on the
24 admissions for the day. If I had one admission, one
25 nurse will be dealing with it; if there is two or three,

1 I don't know how they divide, you know, because the
2 in-charge nurse on the landing, they will delegate the
3 work for the other nurses as well, so I don't know how
4 they allocated the system, which one to care.
5 Q. That is not something that you know?
6 A. Not me, the nursing duties, how they allocate is beyond
7 my ...
8 Q. Just another question or two about the nursing
9 structure. How were the nurses organised? Who was in
10 charge of them?
11 A. In the landing always there is one in charge like
12 F grade, like management, so the F grade in charge, it
13 can be a health care officer or a nurse in charge.
14 Q. So you could have a senior health care officer?
15 A. Or senior --
16 Q. To whom the nurses answered, could you?
17 A. Because on the landing, always there is one in charge of
18 the landing for that particular shift, so we will
19 discuss with that person, so under that there will be
20 other nurses, health care officers, but I don't know how
21 the detail are, what sort of duties they are supposed to
22 do but each landing, both R1 and R2, they had an
23 in-charge person.
24 Q. Do you remember Kay George?
25 A. Yes.

1 Q. What was her role?
2 A. Her role, I think she was, I remember, senior, nurse,
3 you know she was, I think she was maybe H grade,
4 I think, H grade I think, she was the senior nurse
5 there. She was not -- mainly in the management, she was
6 not mainly working in the health care centre, the
7 inpatient unit, but she was one of the nursing, she was
8 the nursing manager so --
9 Q. She was the nursing manager. Was she the senior --
10 A. She was the nursing manager. I don't know how they
11 classify their thing, but she was one of the senior
12 nurses there.
13 Q. I'm trying to understand what sort of interaction there
14 was between the nursing staff and the doctors. Was that
15 something that, it happened on a day-to-day basis, did
16 it, in relation to individual patients, but in
17 management terms, it sounds as if the two structures
18 were separate?
19 A. I don't know how the nurses structure, management wise,
20 their control and everything, but day-to-day workwise,
21 there is a health care officer or a nurse in the
22 landing, you know, in the health care, we normally
23 discuss, whoever on duty, about our patients.
24 Q. I have asked you about management plans and nursing care
25 plans. If somebody in the health care centre was also

1 on an open 2052SH, they would have also a support plan?
2 A. Yes.
3 Q. Is that right?
4 A. Yes.
5 Q. First of all, what sort of, at any one time, can you
6 offer a view about this, what sort of proportion of
7 inmates in the health care centre would have been on
8 open 2052SHs?
9 A. It depends on time to time, it varies, you know,
10 sometimes you can have ten, I can't exactly figure.
11 Q. I'm not asking for an exact figure. I wanted to try and
12 get a feel for whether it would be exceptional to have
13 a person on an open 2052SH?
14 A. No, it is quite common, because a lot of the self harm,
15 mental health problems and drug problems, self harm is
16 quite common, that is why most of them are in the
17 health care as well.
18 Q. So of the people in the health care centre for mental
19 health reasons, can you offer a view as to what sort of
20 proportion of those would have been on open 2052SHs?
21 A. Depending on the mental disorder, whether it is
22 personality disorder or any, maybe at any time, there
23 would have been about eight or ten, because we used to
24 discuss all that in the ward rounds, so there may be
25 about ten, maybe about ten, I suppose, yes.

1 Q. What sort of proportion is that of the total?
2 A. We had -- the capacity was about 48, I think at that
3 time, depending on sometimes before the closure, maybe
4 about 52, I think we had about maybe about 48 inpatient
5 unit, so at least about maybe about ten people, maybe.
6 Q. Now, the support plan that forms part of the 2052SH?
7 A. Yes.
8 Q. Would you be responsible for the support plan for your
9 patients that are on 2052SHs, or is somebody else
10 responsible for preparing that?
11 A. As I told you before, in the health care centre it is
12 a teamwork, because the doctors, nurses, health care
13 officers, so the support plan mainly, I mean, they need
14 the other, whether they are on the 2052SH, they need
15 some support plan anyway for them in be in the
16 health care. But particularly if they are on the 2052,
17 we normally ask for additional help, referring them to
18 the chaplain or listeners, you know, we write it down in
19 the care plan there as well, but the carry out by the
20 nursing staff, you know --
21 Q. Is the care plan and the support plan, are they likely
22 to be exactly the same, or is there something new that
23 is brought to bear in the support plan for an open
24 2052SH?
25 A. No, the support plan, it is the self harm, risk of

1 self harm, so we need to find out whatever support they
2 need for that particular one, but the care plan is
3 totally, not only the overall person, you know what sort
4 of things, if there is physical problems or mental
5 health problems or overall care, they will have it
6 written down in their nurses' care plan.
7 Q. The support plan in the 2052SH is part of a document
8 that is available to everybody, is it, the nursing
9 staff, the doctors and also the discipline staff?
10 A. It is kept in the nurses' station, so I mean it is
11 available, it is obvious, that is the whole purpose,
12 they must know what is in the 2052. It is not like --
13 IMR is the inmate medical record, it is confidential
14 information and a lot of reports and everything and
15 it is all kept in the nurses' station but the 2052 is
16 something once we discharge from the health care centre
17 to the ordinary location, wherever they go it
18 accompanies, so it is not like the IMR kept in the
19 health care.
20 Q. What I was interested in is this: that the IMR is not
21 a document that the discipline officers have access to?
22 A. Not usually, no.
23 Q. But the 2052SH is a document that they have access to?
24 A. Actually it started this, the 2052SH is mainly, you
25 know, initiating the health care. That is the whole

1 purpose, having some sort of observation. The 2052,
2 they are kept in the ordinary location, so it is by the
3 discipline officers, everybody.
4 Q. Should the discipline officers be familiar with the
5 content of the 2052SH? Should they be familiar with why
6 somebody has been placed on that?
7 A. Obviously they should know why somebody is on 2052.
8 Q. How do they come to find out? How is that information
9 passed around the discipline officer staff, the nursing
10 staff? Are they expected to read it for themselves or
11 is there some other system?
12 A. No, in the health care also, the health care staff, the
13 nursing, there is a thing called handing over. There is
14 a shift in the morning, the night staff will hand over
15 to what happened overnight, to the day staff around
16 7 o'clock, or 7.30 they come, whoever is in charge for
17 that landing. They go through, as I told you on the
18 board, they have the names of the patients so they will
19 go through, just like handing over our patients to us,
20 they go through the next shift of nurses, in charge they
21 would tell exactly what happened. So there is handing
22 over, so they will know who is on 2052 as well, you
23 know.
24 Q. I want to talk to you about ward rounds. You use the
25 expression "ward rounds" in your statement in two

1 slightly different ways, as I understand. The first is
2 an actual ward round where you, we have already talked
3 about it, you as a doctor go around and you see each of
4 your own patients, and you have explained obviously you
5 have other duties as well, but that should happen pretty
6 much every day?
7 A. Every day, yes.
8 Q. If not every day?
9 A. Yes.
10 Q. Quite separately, you tell us in your witness statement
11 that Dr Yisa had twice weekly a ward round?
12 A. A formal ward round, yes.
13 Q. But that wasn't a ward round in the sense that we might
14 understand it of going round each inmate but rather it
15 was a meeting in his room, as I understand it, is that
16 right?
17 A. Yes, because even with the things I'm telling you about
18 the ward round, I go and see everybody, not everybody
19 want to hear other person's problems. Sometimes if
20 I want to talk to him, I will take him to the room.
21 Always we had a problem with accommodation, because it
22 was an old hospital wing, and the problem of getting the
23 space to see inmates. Sometimes you had to see them
24 inside their cell, or sometimes you may take them on the
25 clinic consultation room and they will have more privacy

1 to talk about the problems.

2 Q. Can I just focus --

3 A. It is like in the psychiatric hospitals, because even in
4 the psychiatric hospitals, not like in the general
5 hospital, you don't go with the trolley to each patient,
6 because there is a lot of confidential things we
7 discuss.

8 Q. Let me just focus on what actually happened at these
9 twice weekly formal ward rounds, please?

10 A. So these ward rounds, we normally have this formal ward
11 round in Dr Yisa's office, because it is the biggest
12 space in that hospital area. It is the biggest one
13 where a lot of people can accommodate in that room.

14 Q. Can we just focus on what happened?

15 A. So for the ward round we take all the IMRs of the
16 inmates and all the doctors working in the inpatient
17 unit and the nurse in charge, whoever are R1 and R2
18 observations for their different areas, so whoever is in
19 charge will be coming for the ward round with their care
20 plans and the treatment cards. Dr Yisa chairs the ward
21 round and we will have the pharmacist as well, because
22 we discuss about all the medication and everything, so
23 the pharmacist comes routinely and the probation
24 officer, but again the probation, one time they were
25 coming regularly and then they took away the health care

1 probation officer. When they were available they also
2 come for the ward round, so we discuss about everybody,
3 so we discuss about the 2052SH in that ward round, twice
4 a week we discuss about the 2052SH.
5 Q. This is a discussion that relates to everybody in the
6 health care centre?
7 A. Inpatients, yes.
8 Q. How long would this meeting take?
9 A. I think maybe about three or four hours, depending on
10 because always we discuss about the new patients,
11 because those are the ones we don't know, so the
12 allocated doctor, I had to present the case, because --
13 so during the ward round we discuss about all the new
14 admissions to the health care centre, and usually
15 presented by the doctor who clerked the patient, and
16 then the nurses will give their account of what was
17 happening and what sort of things, their concerns, and
18 whether we have got any information from outside. So we
19 discuss about the patient, and what we have done so far,
20 whether he was referred to the psychiatrist or whether
21 he was seen by the psychiatrist, whatever the care
22 up-to-date we discuss about the patient there.
23 Q. The doctors would present to this ward round their own
24 patients?
25 A. Yes.

1 Q. So that would give the -- twice a week it would give the
2 allocated doctor, if they had not already had an
3 opportunity, an opportunity to review what was happening
4 in relation to the care of their particular patients.
5 They would present that to the ward round so that
6 everybody would know?
7 A. Yes.
8 Q. Presumably decisions could be taken?
9 A. Yes.
10 Q. About what needed to be done?
11 A. Yes.
12 Q. Dr Yisa as the senior medical officer might offer
13 advice, presumably?
14 A. Of course, yes.
15 Q. About what he thought needed to be done?
16 A. Yes. We don't wait until the ward round to discuss
17 about the patients with the nurses. We do this daily as
18 I told you before.
19 Q. But in relation to somebody who wasn't a new inmate that
20 had already been in the health care centre for some days
21 or maybe weeks, what was the point of this meeting? In
22 relation to new people, it is clear that they are new
23 and you need to understand what the position is with
24 them and everybody needs to know. In relation to
25 established inmates, who have been there for some time,

1 what was the purpose of this meeting?
2 A. We need to know, because the inpatient, you know, it is,
3 there is only limited spaces and there are a lot of
4 demand for the inpatient unit, so we have to discuss and
5 update about really the patient regularly. One thing
6 about the progress and who can be discharged to
7 accommodate the new patients coming in, and what sort of
8 medication, are they getting the correct medication and
9 a lot of things we discuss there. So overall, in
10 addition to the daily whatever we do the reviews, it is
11 a very good place to discuss, it is like
12 a multi-disciplinary, pharmacist and everybody there,
13 the doctors and nurses and everybody gives their ideas
14 about a lot of things.
15 Q. In relation to those inmates who are on 2052SHs, was
16 that meeting also the case conference in relation to the
17 people on the 2052SHs, or was the case conference for
18 those people something quite separate?
19 A. During that time we used to discuss about the 2052 case
20 conference at the same time when we discuss about the
21 patient, self harm and a lot of things, it is quite
22 relevant, the same sort of things, our plan, our support
23 plan for the patients, so we discuss the 2052 during
24 that ward round, but later, I mean, in the introduction
25 of the mental health team and everything, it became

1 separate later stage.
2 Q. I think in December 2001, we may need to check this, but
3 I think that the mental health team had not started?
4 A. I think they were introduced in 2001, but the whole
5 team, it took several months to establish the whole
6 team.
7 Q. But in any event, before that new system?
8 A. Before that, yes.
9 Q. These ward rounds doubled up, did they, as the case
10 conference?
11 A. Yes.
12 Q. For the inmates in the health care centre on 2052SHs?
13 A. Yes, yes.
14 Q. You say that they were attended by the nurses, and by
15 probation, I think I paraphrase, but I think you were
16 really saying sometimes by the probation?
17 A. They used to come regularly, but the regular one we had
18 for the health care, because of the shortage, they took
19 him away, so if we wanted a probation officer, it
20 depended on who was on duty for the day.
21 THE CHAIRMAN: When are we talking about now, December 2001?
22 A. I can't exactly remember, because we used to have --
23 I can't remember.
24 MR MORTON: Were inmates who were on 2052SHs allocated key
25 workers, do you know?

1 A. I don't think in the health care they had the key
2 worker, I'm not sure.
3 Q. You don't think they did?
4 A. I don't know whether they, whether the nurses, whether
5 they had any particular -- I'm not sure.
6 Q. Did the health care officers attend this twice weekly
7 ward round?
8 A. Yes, depending on who was on duty, really.
9 Q. Did the prisoners themselves ever attend?
10 A. Not all the time, no. Usually, I mean, if you are
11 concerned -- sometimes we get, it is not routinely we
12 get everybody, because it is a three-hour ward round.
13 If you are going to get 48 inmates there as well and
14 some people are not suitable to come up there anyway,
15 they disturb people as well, but sometimes after the
16 ward round if you are concerned about some inmates, when
17 we discuss with Dr Yisa, we will go down and be with
18 them in their own cell as well, that we used to do.
19 Q. Would the psychologist ever attend, for example?
20 A. The psychologist, no, because they are -- the visiting
21 psychologist, we have not had that luxury for somebody
22 to come and sit down all the time during our ward round.
23 Q. Would the chaplain ever attend?
24 A. Chaplain, sometimes, not regularly, but if they are
25 concerned about sometimes, because it is quite

1 a friendly -- you know, everybody they are concerned
2 about, they may sometimes come and talk to Dr Yisa. It
3 is quite a free place for Dr Yisa's office, anybody
4 concerned --
5 Q. The reason that I ask you these questions is that in
6 relation to patients on a 2052SH, there was a policy
7 document, was there not, issued by the suicide
8 prevention team in 2001? Could you have a look at
9 bundle 8, page 9, please.
10 A. Which one?
11 Q. Tab 9?
12 A. Yes.
13 Q. That suggests at page 9 of that document -- first of
14 all, let me take it one stage at a time, have a look at
15 the document itself; is that something you are familiar
16 with or were familiar with or not?
17 A. This is -- mainly the 2052 is not only kept in the
18 health care. This is what is happening in the main, in
19 the wings, they must have this member of, members of
20 the -- each mentioned here. So I don't know how many
21 people attend, I don't know what is happening in the
22 wings, but ...
23 Q. I take your point that this related to the whole prison?
24 A. Yes.
25 Q. Is it a document that you have seen before?

1 A. Yes, yes.
2 Q. If you just have a look, let me ask you to comment,
3 please on, page 9?
4 A. Yes.
5 Q. There is a page headed "Managing Prisoners on 2052SH"?
6 A. Yes.
7 Q. The second paragraph:
8 "Unit managers will identify a key worker for every
9 prisoner on an open 2052SH."
10 Is that something that happened in the
11 health care centre?
12 A. So I don't know whether the nurses, whether they had the
13 key -- that I can't comment, whether they had allocated
14 a particular nurse or the officer as a key worker,
15 I don't know.
16 Q. You don't know?
17 A. No.
18 Q. Under "Case Reviews", halfway down the page, it says:
19 "Principal officers are responsible for ensuring
20 that reviews are scheduled on a weekly basis and minimum
21 attendance by..."
22 Then it lists a series of people, and I'm not going
23 to read them all out, some of them if available and the
24 prisoner if agreeable. Those were the sort of people
25 I was listing for you.

1 But it sounds as if, tell me if I have this right,
2 that in the health care centre there wasn't a specific
3 system for case reviews of people on 2052SHs, but rather
4 it was part and parcel of Dr Yisa's twice weekly ward
5 round; is that right, or is that wrong?
6 A. All the 2052SH, that is our routine, normally, we
7 discuss at the case conference case review and we
8 document there in you know in the 2052SH case, the case
9 review and usually the people, like the probation,
10 I mean, depending on availability, chaplain not
11 regularly but if they are concerned, of course they may
12 come and discuss about any particular patients, so they
13 are welcome to participate in the --
14 THE CHAIRMAN: The question is, were there separate case
15 reviews other than the discussions that took place
16 during the twice weekly ward round?
17 A. The case review -- those are the two, I mean twice
18 a week we discuss all the case, we discuss, but later as
19 I told you, it changed to, they had the separate, they
20 took it --
21 THE CHAIRMAN: But at the time it was part of the ward round
22 and there were not separate --
23 A. I can't particularly tell this period, because I don't
24 know when it changed, you know, maybe during the 2001,
25 2002, I don't know, the 2052 case review was taken away

1 from the usual ward round.
2 THE CHAIRMAN: As it is now nearly 11.50, I think we will
3 take a short break there. We can reconvene at noon if
4 we may. We will have a break.
5 A. Thank you.
6 (11.50 am)
7 (A short break)
8 (12.00 noon)
9 THE CHAIRMAN: We will resume if we may.
10 MR MORTON: Just a final couple of questions, if I may, on
11 the case conferences for those on 2052SHs. It sounds
12 from what you are saying as if your recollection of
13 these case conferences, forming as they did part of the
14 ward rounds, were multi-disciplinary in the sense that
15 you had a number of people there, you recollect the
16 doctors, the nurses, the --
17 A. The probation.
18 Q. The probation, and I'm not sure if I have got this
19 right, I think you said the health care officers as
20 well?
21 A. Yes.
22 Q. I just want to ask you about that, because
23 Carole Draper, as you know, conducted an investigation
24 into Mr D, and she also conducted an investigation into
25 another man at about the same time, and I'm not going to

1 say his name, but could you have a look at bundle 9,
2 please. If you look in bundle 9 you will see, I'm not
3 asking you to read it, but you will see that is a report
4 into another incident and if you look at the name it may
5 jog your memory. Do you remember him?
6 A. I can't remember.
7 Q. Don't worry about the detail of that, but this was an
8 incident in the health care centre at Pentonville on
9 3rd November 2001, so a little under two months before
10 Mr D. And the recommendation in both that report and
11 also in Carole Draper's report into Mr D was that case
12 conferences on 2052SH should be multi-disciplinary in
13 health care, and the prisoners should be present during
14 the discussion. In relation to Mr D, she, Carole Draper
15 added:
16 "Landing staff with day-to-day responsibility for
17 the prisoner should also be present."
18 So that certainly suggests, doesn't it, that those
19 investigations revealed that case conferences in
20 relation to those on 2052SH in health care were not
21 routinely multi-disciplinary; can you account for that
22 apparent --
23 A. When I think about multi-disciplinary, as I told you
24 before, the presence of the SMO, the presence of the
25 doctors, the presence of the nurse, who were on the

1 landing, you know, because for the R1 case conference
2 for the R1 inmates, usually whoever in charge or whoever
3 represented from the R1 will come for the rounds, so
4 they know about what is happening on that landing. For
5 the R2 landing, the inmates, the person who is working
6 there, one of them will come there.
7 Q. Were you ever made aware of those recommendations?
8 A. No, I mean, I have not read all of this.
9 Q. No, I'm not suggesting that you should have read them
10 before today, for today's purposes, but I was wondering
11 whether at the time?
12 A. If it was -- after any recommendations, if it is
13 relevant, they will write to like the SMO, if there is
14 anything relevant to the health care or for the doctors,
15 they would have brought it to our attention, you know.
16 Q. Can you recollect having brought to your attention that
17 there were two reports that had recommended in
18 health care centre, in the health care centre, case
19 reviews should be multi-disciplinary, that the landing
20 officer should attend and that the inmate should attend?
21 Can you remember that being drawn to your attention?
22 A. I can't remember. It is about seven years, or six years
23 ago, so I can't remember.
24 Q. I want to move on if I may to a different topic, which
25 is the system for referral to psychiatrists and

1 psychologists.

2 Now you deal with this in your witness statement,

3 which you might want to have in front of you at

4 paragraph 15, I think.

5 Now, in Carole Draper's report, she suggests that

6 Mr D was referred under the old system of referral,

7 because you make the point in your statement that the

8 system changed round about 2001 and I think you cannot

9 recall precisely when?

10 A. I can't remember, and what sort of -- I don't know how

11 this Carole Draper, which system used I don't know,

12 because I have never met Carole Draper or she never

13 interviewed me, so I can't comment.

14 Q. I understand that. The reason that I suggest that is

15 that, if you, there is no need for you to look at it,

16 but one of her conclusions is she says at

17 paragraph 7.1.1 for other people's reference, she says:

18 "Health Care Referral Systems. Although new systems

19 have been introduced following an internal review which

20 had nothing to do with the incident involving Mr D,

21 managers in health care and visiting specialists still

22 have concerns about the integrity of their current

23 system for referring prisoners to either specialists or

24 other departments."

25 MR EADIE: It might be as well for her to see that if you

1 are going to ask her questions about it. 7.1.1
2 of Draper, please. Bundle 4, the Draper report,
3 paragraph 7.1.1. Thank you very much.
4 MR MORTON: I'll just give you a moment to read
5 paragraph 7.1.1 to yourself, doctor.
6 A. Yes.
7 Q. I read that, but I entirely accept it is only my
8 interpretation, that the system under which Mr D was
9 referred was the old system of referral and not the new
10 system of referral.
11 I don't suppose -- you cannot actually recall, can
12 you?
13 A. I can't comment on, as I told you before, because she
14 never interviewed me, I can't comment, it is not my
15 comments she had mentioned in her report, so I can't
16 comment on that.
17 Q. But then in your witness statement you deal with both
18 the systems?
19 A. Yes.
20 Q. At paragraphs 15 and 16.
21 Now, can I try and paraphrase this, that under the
22 old system, Dr Talat would allocate those who had been
23 identified as needing referral to a psychiatrist to
24 a psychiatrist?
25 A. It is mentioned on the ordinary location. This is not

1 true with the inpatients.
2 Q. So the position in relation to the inpatients?
3 A. Inpatients, I mean the reference is coming from the
4 inpatients as well as from the ordinary location.
5 Q. Let's leave ordinary location out of account.
6 A. So you want the old system.
7 Q. Yes.
8 A. Once we finish clerking, and on the plan, we will decide
9 which psychiatrist needs to be seen, whether he
10 is forensic psychiatrist, which psychiatrist, and then
11 we will write down everything, refer to the particular
12 name of the consultant for mental state assessment by
13 whatever the psychiatrist. We document that in this
14 IMR, and then we go to the administration office which
15 is in the same building, on the third floor where we
16 have all the doctors' offices, SMO office, the same
17 landing. We go to the admin office and find out from
18 the admin office staff, the health care admin office
19 staff, the psychiatrist who is available for the week,
20 you know, because they have got the visiting
21 psychiatrist, appointment books in the pigeonholes in
22 the same health care centre.
23 Also the admin office, they are the people who make
24 the clinic lists, so we know which consultant -- they
25 had a list as well, which psychiatrists come in what

1 day, so from them we will find out who is the
2 psychiatrist who is next available, depending on the
3 urgency for the particular inmate.
4 Q. So the doctor who has undertaken the clerking?
5 A. Yes.
6 Q. Will conclude that the person needs to see
7 a psychiatrist?
8 A. Yes.
9 Q. Will decide what sort of psychiatrist?
10 A. Yes.
11 Q. Will then go to the area you have described?
12 A. Admin office, yes.
13 Q. Identify when the appropriate psychiatrist is next
14 available?
15 A. Yes.
16 Q. And what, make an entry in their list?
17 A. In the admin office they will enter their name, because
18 each consultant, during that time they had from the
19 Camlet Lodge, the visiting forensic psychiatrist used to
20 come from the Camlet Lodge, that is the
21 North London Forensic Service; and from the East London,
22 that is the John Howard centre, the forensic
23 psychiatrist. In addition we used to have Dr Hadjiof
24 and Dr Hurst, two general psychiatrists, retired
25 psychiatrists who used to come regularly.

1 Q. If a patient was put into the list of one of the
2 doctors, one of the psychiatrists, would there be any
3 reason for him to be seen by one of the other
4 psychiatrists?
5 A. Yes, they will when they enter the name for that
6 particular one, they will enter him, they do the clinic
7 list, they will put his name in the clinic list for that
8 particular psychiatrist. And for some reason if they
9 are not seen or something, or if they need any urgent
10 psychiatric review, depending on the circumstances of
11 the inmate, another psychiatrist can see him, yes.
12 Q. How would the other psychiatrist know, so let's take
13 Mr D, let's be more specific about it. He was
14 identified to be seen by Dr Akinkumni, I think, if
15 I pronounced his name correctly, who is a forensic
16 psychiatrist?
17 A. Yes, forensic, yes.
18 Q. If it was under the old system, you would have entered
19 his name, because you were the allocated doctor, you
20 would have entered Mr D's name in Dr Akinkumni's list?
21 A. Usually the admin office --
22 Q. They do the entry.
23 A. So they will enter the name and they will prepare the
24 list as well, the clinic list.
25 Q. If for whatever reason Mr D is not seen by Dr Akinkumni,

1 how would another psychiatrist, one of the general
2 psychiatrists, for example, how would they know that he
3 had not been seen and how would they have had occasion
4 to see him themselves?
5 A. Because I mean, unless we refer to another psychiatrist,
6 they don't know about the inmates, so if you are
7 concerned about the patients while you are waiting to
8 see the allocated psychiatrist, we can ask another
9 visiting psychiatrist to assess him for urgent
10 assessment, yes.
11 Q. So the point is this, is it, if he was not seen, the
12 patient is not seen by the allocated psychiatrist, it is
13 for the doctor to identify that and then to put him in
14 the list for one of the other psychiatrists?
15 A. It is not only the doctor, I mean, because in the
16 health care, the nursing staff, they are there all the
17 time in the health care centres, so they know when the
18 psychiatrists are coming, they have more time to spend
19 in the health care inpatient unit; so if they are not
20 seen sometimes, they can ask not only the doctor, if
21 they are concerned about somebody, you can ask another
22 visiting psychiatrist. That doesn't mean that you would
23 not put the name in the list, to make it in the clinic
24 list. As an emergency, if I'm concerned about like D,
25 if I think he was very self harm which you are concerned

1 about his mental state and his behaviour during that
2 time, we will go and ask Dr Hadjiof. That doesn't mean
3 that you have to put the name in the clinic list. We
4 will approach them and discuss: we have got a patient
5 that have some problem, could you please assess him and
6 we will tell, he is awaiting visit of the psychiatrist
7 but is not yet seen.
8 Q. Was there any means of prioritising who should be seen
9 by the psychiatrists? I mean if, I don't know whether
10 it ever happened, for example Dr Akinkumni's list is
11 simply too long for him to see everybody in the time
12 that he is next in the prison, what would happen then,
13 or did that ever happen?
14 A. Of course, yes, because sometimes, for some reason if
15 they don't come or not seen, they have many people
16 already on their list, because the forensic
17 psychiatrists, they will need quite a lot of time,
18 because of the detailed assessment they do. Then we
19 will find out who is the other psychiatrist, the next
20 available forensic psychiatrist coming from the same
21 unit. They have the books there, so we know when they
22 are coming and then we will ask the admin office to
23 change the name to particular, who is the next available
24 psychiatrist.
25 Q. So the system ought to have operated to identify whether

1 or not somebody has been seen and if they have not been
2 seen, to ensure that they were?
3 A. Yes, because if somebody is not seen it will be, I mean,
4 found out by, one thing by the doctor who is their
5 allocated doctor and by the nursing staff who is there
6 all the time, they will know whether he was seen or not;
7 and also twice a week ward round, we will know whether
8 he was seen or not. So there are quite a lot of ways we
9 will find out why he was not seen, and while waiting to
10 be seen by the particular psychiatrist, asking another
11 psychiatrist is quite a common thing, because sometimes
12 we need to have the second opinion.
13 Q. Under the new system, you deal with that in paragraph 17
14 of your witness statement, under the new system, as
15 I understand it, that required a written, sorry,
16 paragraph 18 of your witness statement, that required
17 a written referral to the mental health in-reach team?
18 A. Yes, with the introduction of the in-reach -- I imagine
19 the introduction was done in 2001, you know, the same
20 period when the others happened, and then the referral
21 system also changed obviously when this started, with
22 the introduction of the mental health team, so they
23 introduced a form as well. So for the psychologists as
24 well as for the psychiatrists, we had to fill a form.
25 In addition to write, we still write in the IMR,

1 whatever the record, so and so, we had to fill the form.
2 I think even that form, from time to time they changed
3 whatever the thing, but we had to fill the form and then
4 we had to go and give it to the admin office, and the
5 mental health team there was a team who would go through
6 all the referral forms and decide which psychiatrist to,
7 you know, put for that particular inmate.
8 Q. You were here yesterday, I think, when Dr Yisa said that
9 this system, the system that you have just described,
10 wasn't effective and he described it as removing
11 a safety net, I think was his expression, the safety net
12 provided by the old system.
13 Do you agree with that? What was your experience of
14 the new system?
15 A. Yes, we always, whatever happened, one of my patients
16 was not seen, like D if he was not seen, I would have,
17 when we found out, not only the nursing staff, I would
18 have gone and find out why he was not seen and I will
19 have my freedom, you know, go and ask the admin office,
20 who is the one coming next, can you add the name, easy.
21 But with this new system referring the form, because we
22 have already done the form, so the allocation, I mean we
23 have not -- we couldn't do the way, you know, the doctor
24 was not able to do it as we used to do before, because
25 they did the allocation, you know, rather than the --

1 Q. Do you agree with Dr Yisa that the new system was not
2 effective?
3 A. During that time, I mean the things has changed over the
4 years now, but during that introduction time, the
5 referring form, we used to go and complain to Dr Yisa,
6 because whatever the patient was not seen, as a line
7 manager, we always go to Dr Yisa, if they are not seen
8 and everything we discuss about. So that time, I think
9 with the introduction, quite a lot of, you know it
10 started all this system. It was not ideal to whatever
11 we used to do, because we had quite a lot of safety
12 netting, you know, we had that.
13 Q. Could you have a look at bundle 1, tab 10, please,
14 page 122.
15 A. Yes.
16 Q. This is your handwriting?
17 A. This is my handwriting.
18 Q. I'm going to ask you about the detail of this form in
19 a moment. The only reason that I'm asking you to look
20 at it now is to see whether it helps you identify which
21 system was being operated. This is obviously a form for
22 a written referral, both for psychiatry and psychology.
23 Can I ask this: was this form part of the new system or
24 did this form exist under the old system?
25 A. This form was started from the Camlet Lodge, Dr Halsey,

1 because though it says it is
2 North London Forensic Service form, and though it is
3 psychiatry and psychology, it was mainly for the purpose
4 of doctors -- they introduced this one --
5 Q. This doesn't relate to the change in the system for
6 referral at Pentonville?
7 A. This one was introduced before the written referral for
8 the psychiatrist, at the same time when they introduced,
9 whether he still continued with this form, I can't
10 remember, I can't comment on that.
11 Q. I wondered whether this form would help you say whether
12 you were operating under the new or old system
13 in December 2001, but it doesn't sound like it's going
14 to help you.
15 A. The thing is when they are introducing a new one, quite
16 lot of overlapping happened with the old system and new
17 system, so I can't remember just writing this form means
18 that we followed the new or the old system.
19 Q. We will come back to that in a moment. You can put to
20 it one side for now.
21 You mentioned that one of the issues for the doctor
22 during the clerking process, if a psychiatrist is to be
23 instructed, is to identify what sort of psychiatrist was
24 needed?
25 A. Yes.

1 Q. We know that Dr Akinkumni to whom Mr D was going to be
2 referred, is a forensic psychiatrist?
3 A. Yes.
4 Q. What is the significance of that? Why would you
5 identify a forensic psychiatrist as being appropriate,
6 rather than a general psychiatrist?
7 A. Most of the time for the inpatients we used to refer,
8 because most of them, they are either mentally ill or
9 who need, sometimes they may need a transfer to outside
10 hospital, psychiatric units, so the forensic
11 psychiatrists, they have access to the forensic units
12 outside, you know, in the hospitals outside.
13 Q. In what circumstances would somebody be transferred
14 outside? Does that indicate a particular type of
15 psychiatric illness or a particular severity of
16 psychiatric illness?
17 A. It depends on what sort of -- from the previous, whether
18 they had already some sort of mental illness or
19 sometimes even the psychiatrists, they are not sure,
20 just doing one or two assessments, in the prison, they
21 cannot come to a diagnosis, so sometimes they had to
22 under section, they had to transfer them under
23 section 48 to the Home Office, or from the courts to
24 ensure for assessment period in a psychiatric unit.
25 Q. So if you identify a forensic psychiatrist as being the

1 appropriate psychiatrist, does that indicate in your own
2 mind that you think it is at least possible that this
3 person is sufficiently unwell to require treatment in
4 a psychiatric unit outside of the prison?
5 A. No, that is not the only thing why we are asking for the
6 forensic psychiatrist. Sometimes the nature of the
7 charge, that is quite relevant. Here he is here for
8 possession of an offensive weapon, like a firearm
9 offence and offensive weapon, we normally used to refer
10 to the forensic psychiatrist and also like murder cases
11 and sexual offence, those nature of charge automatically
12 go to the forensic psychiatrist. Sometimes they may ask
13 for a court report from the -- also they would have been
14 known to the unit before, the personality disorder, or
15 anything, sometimes they would be known to the unit in
16 the past.
17 Q. I'm going to ask you about Mr D in a moment and
18 I appreciate as you say yourself and as you have said
19 before, it has been a long time since you dealt with
20 Mr D, but are you able to recall now why you referred
21 Mr D to a forensic psychiatrist as opposed to a general
22 psychiatrist?
23 A. As I told you before, I mean, I can't remember, but
24 the -- one thing which may be the possession of
25 offensive weapon is something, the nature of the charge

1 goes to --

2 Q. But possession of an offensive weapon must be really

3 a very common charge?

4 A. Offensive weapon, we don't know the detail, it may be

5 firearm which can be very dangerous. I have not got any

6 detail of that one.

7 Q. Would that be, I don't know, Dr Ranaweera, would that be

8 sufficient of itself to refer to any psychiatrist, let

9 alone a forensic psychiatrist?

10 A. In this case, I mean, I'm just looking at the referral

11 to the psychologist, this one, I mean he had quite a lot

12 of uncertain things, in this, from my initial assessment

13 which I have written on the 3rd, so by that time I would

14 have clerked him, I wouldn't have had a chance to get

15 all the previous information from the outside services

16 on the same day, because there is a referral I normally

17 do on the first day when I clerk the patient so I want,

18 though I request for the outside information, I will not

19 get by the time I do the referral on the first day.

20 So here I've written he has got the problem with

21 alcohol abuse, past history of mental illness; I have

22 put query. Query means the diagnosis. This is what he

23 say that he had been seen by a psychiatrist, he was not

24 sure himself. According to that he was referred to

25 St Clement's hospital in the past, so that means he had

1 some access to the psychiatric services in the past. At
2 the same time we don't know the diagnosis and the other
3 thing, self harm, on 2052SH he was on self harm, and
4 violent behaviour as well, violent behaviour at times,
5 smashed two cells. He had come on 30th November. By
6 the 3rd, for me to write smashed two cells, he already
7 had quite disturbed behaviour, and in addition to
8 whatever the alleged offences, the possession of an
9 offensive weapon, with all this taken into account, I
10 would have taken the whole person into account, the
11 information available for me to refer to the forensic
12 psychiatrist, rather than the general psychiatrist.
13 Q. What I'm coming to is this: I'm still trying to
14 understand why a forensic psychiatrist as opposed to
15 a general psychiatrist.
16 As best you can from those notes, can you identify
17 what it was about that history that made you think that
18 a forensic psychiatrist was appropriate?
19 A. Because there are quite a lot of uncertain -- I mean the
20 thing is, I am not sure, but although he had access to
21 the St Clement's hospital, the diagnosis was not sure
22 and also --
23 Q. Why does that indicate a forensic psychiatrist as
24 opposed to any other sort of psychiatrist?
25 A. If he was assessed by a forensic psychiatrist, then the

1 next stage, if they think that the person needs either
2 mentally ill, it will facilitate rather than asking --
3 changing from one psychiatrist to the other one, to be
4 seen by a forensic psychiatrist --
5 Q. A psychiatrist treats people who are mentally ill?
6 A. Not only mentally ill --
7 Q. What is it that is significant about a forensic
8 psychiatrist?
9 A. Because when we assess, when they come to the prison,
10 it is completely -- we don't know about the person. We
11 try to get a lot of information from outside, from our
12 information what is available in front of us with the
13 inmate, what is happening there, so a lot of things and
14 also come to a diagnosis and if we need to go to outside
15 hospital, we think all of that when they come to the
16 inpatient unit, we tend to ask the forensic
17 psychiatrists to assess the patients, for the
18 inpatients.
19 Q. Would you as a matter of routine then refer those that
20 need psychiatric assessment to forensic psychiatrists?
21 A. I would not use the word routinely, but mostly the
22 inpatients, we refer to the forensic psychiatrists,
23 because the general psychiatrists they have to assess so
24 many people from the outpatients, their list is quite
25 long, because they have to assess so many other people

1 in the ordinary location, so I can't refer inpatients
2 also to the forensic psychiatrists.
3 Q. Was the reason that Mr D and people more generally were
4 referred to forensic psychiatrists because you thought
5 they were more likely to require sectioning?
6 A. That is part of it. At the same time by looking at it,
7 this man has got -- from the initial assessment, this
8 is, he has got quite a lot of pathologies which he need
9 a full assessment, by a psychiatrist, usually for the
10 inpatients we tend to ask the forensic psychiatrist
11 and --
12 Q. The reason I ask that question is I wondered if you
13 could be shown bundle 8, tab 6. This is, I'm afraid, an
14 undated document, doctor, so you may be able to say that
15 it is not relevant at all to December 2001. I'm afraid
16 I don't know the answer to that. I'll give you a moment
17 to read it. Just look at the first page.
18 A. Yes, I have read this.
19 Q. Are you familiar with it?
20 A. Yes.
21 Q. It relates to first of all health care centre patients
22 being allocated to a named full-time medical officer for
23 day-to-day care. We have dealt with that.
24 "Inpatients may be referred to visiting specialists.
25 Such referral should be specific as to the intention as

1 much as possible."
2 A. Yes.
3 Q. If we go down to the third bullet point, it reads:
4 "Mentally ill patients likely to require section
5 from all areas except east London may be referred to
6 Dr Hamilton, James, or Akinkumni."
7 A. Yes.
8 Q. I read that to mean, but tell me if I have got it right
9 or wrong, section under the Mental Health Act?
10 A. Yes.
11 Q. I have got that right?
12 A. Yes.
13 Q. So that indicates, doesn't it, that the reason for
14 referring to any of those named doctors, is or might be
15 patients you think may require sectioning?
16 MR EADIE: With respect, it doesn't necessarily indicate
17 that.
18 MR MORTON: Perhaps the witness can answer.
19 A. By looking at it, this is one of the indications,
20 mentally ill patients likely to require section from all
21 areas, except east London may be referred to Dr Hamilton
22 and James, because they used to come from Camlet Lodge.
23 "Similar patients from east London will be referred
24 to Dr Boast."
25 Then the nature of charge. Cases include, these are

1 the criteria we used to do, why we refer to the forensic
2 psychiatrist, and under that, offences involving
3 violence or threat of violence.
4 In this patient, there is quite a lot of things. He
5 comes with the possession of offensive weapon. In
6 addition within two days coming to the prison, he smash
7 up two cells, quite disruptive behaviour, whatever the
8 underlying pathology, so he needs a forensic
9 psychiatrist's assessment --
10 THE CHAIRMAN: So I should read the document as including
11 both of those bulleted points, is that the point?
12 A. Yes, the nature of charge always go to the forensic.
13 MR EADIE: The concern I have was that it doesn't
14 necessarily follow from that third bulleted point that
15 Doctors Hamilton, James and Akinkumni are not seeing
16 other sorts of patients who don't require sectioning.
17 THE CHAIRMAN: Because of the use of the word "may".
18 MR EADIE: Yes, it just means that if you think in some
19 cases that it is likely, they are the people you will go
20 to; the opposite however is not necessarily true.
21 THE CHAIRMAN: Thank you.
22 MR EADIE: That was my concern.
23 A. So this is nature of charge. This is what we were told,
24 nature of charge always going to the forensic
25 psychiatrist, and also when you come to the forensic

1 psychiatrist, depending on what area they come from,
2 like North London psychiatrists they cover their
3 catchment area. If it is East London, like Hackney, we
4 normally refer to the John Howard Centre visiting
5 psychiatrist. So the nature of charge always go to the
6 forensic psychiatrist. Under that, offences involving
7 violence or threat of violence, which is one of the
8 things I can say by looking at it, his alleged offence,
9 quite a lot of threat and behaviour problems since he
10 came to the prison.
11 MR MORTON: I think you would also refer to a forensic
12 psychiatrist people that you thought might be psychotic.
13 A. Yes. I mean, depending on whether they are psychotic or
14 severely depressed who need the sectioning.
15 Q. As you have said now and as you say in your witness
16 statement, also if their past mental history suggested
17 that it was required?
18 A. Yes, because some time what happened, these inmates,
19 they keep on coming or sometimes they are known to the
20 services, either North London or East London, so in that
21 case we normally refer to the same psychiatrist, you
22 know, depending on the information available.
23 Q. Now, in relation to Mr D, can I turn and ask you some
24 questions about him as best you can recall and as I said
25 to you earlier, I'll see if I can jog your memory from

1 the material that we do have. We know from
2 Carole Draper's report that Mr D was seen in reception,
3 put on an alcohol detoxification programme, and seen by
4 you on 3rd December; and you assessed him, and
5 considered that he was not actively suicidal or
6 depressed. But you made an urgent referral both to the
7 psychologists and to the psychiatrist. You just have no
8 recollection at all?
9 A. The only thing is as I told you before, there is no IMR
10 for me to go by, what I have written there, and this is
11 Carole Draper's report, I can't comment on that because
12 she didn't interview me, and her report, depending on
13 what observations, what information, so I can't comment
14 on that. The only thing is the admission book, I mean,
15 at the beginning when the interview --
16 Q. I was going to ask you about this. This is the document
17 that you identify at the very beginning. Shall we go
18 back to that?
19 A. Yes, in fact most of the information I got last week,
20 I got four big folders and in that I found this
21 admission book, which for the first time I saw.
22 Q. That is bundle 1?
23 THE CHAIRMAN: Remind me where that is. It is bundle 1,
24 tab...
25 MR EADIE: Tab 5, is it, page 74 and 75.

1 THE CHAIRMAN: Thank you.

2 A. Because last year for the first time when Ali McMurray
3 interviewed me, I didn't know, she just came for the
4 interview and I didn't have any information or anything
5 previously. We just sat down, and just before she
6 recorded everything, she just showed me the information.
7 Until then I didn't have any information about anything
8 at all. I didn't know D or anything.

9 I think the things she showed me was that
10 observation book something and Carole Draper's comment,
11 and even this referral letter which they didn't have,
12 the only thing she said: oh, it says refer to doctor,
13 you are his doctor, Dr Ranaweera, so that assumed that
14 I have seen; and she showed me Dr Halsey's referral,
15 acknowledging that -- that's why only those two
16 information. But now, I mean there is more information
17 like even looking at this page, now I know that I have
18 seen him.

19 MR MORTON: If we just have a look at that.

20 A. I can explain, this is, as I explained to you before,
21 the admissions, when they come from the reception; this
22 is, I'm in the diary which normally, the yearly diary we
23 maintain, on 30th November, after 5.00 pm, and D's name
24 is there, there are several other names I think they
25 haven't released for the confidentiality. The things

1 I have written there, normally if I'm the allocated
2 doctor for the Monday, on-take doctor for the Monday,
3 from Friday 5.00 pm onwards, Saturday and Sunday, there
4 is admission over the weekend, I normally make a list
5 for the Monday, it is easier for me, so this is what
6 I have done, if you look at it on the 30th.
7 Q. He was allocated to you on November 30th?
8 A. The 30th after 5.00, so that means automatically it goes
9 to the Monday morning.
10 Q. Is this your handwriting on this page?
11 A. Yes, this is my handwriting but not the one they have
12 written the name on the 30th, it is not my name, but
13 like before 5.00 pm, after 5.00 pm to make it easier,
14 I normally used to enter that one to make life easier.
15 Q. What you have said on Friday the 30th is Mr D's name is
16 there --
17 A. If you see on the side, I have see list on Monday the
18 3rd --
19 Q. Let's try it this way, can I ask you the question and
20 you answer the question and we will not cut across each
21 other. Looking at Friday the 30th, in this document, we
22 have got Mr D's name?
23 A. Yes.
24 Q. Then you have written, bracketed it with other names now
25 blanked out?

1 A. Yes.
2 Q. Is that list on Monday, 3rd December?
3 A. "See list on Monday 3/12/01".
4 Q. Then we go over the page to Monday the 3rd?
5 A. Yes, if you see Monday the 3rd, there is, before
6 5.00 pm, my name, and there are six admissions for over
7 the weekend for me to see on that day, and --
8 Q. You have seen Mr D, and you have ticked "seen"?
9 A. Seen, refer to psychiatrist, out of six, five, I have
10 seen and refer to psychiatrist on that day; and there
11 was one patient, there is no location in the health
12 care, so I have put query overflow. There is something
13 we have to mention there. There is so much demand for
14 the inpatient unit, sometimes the admissions, they want
15 to admit, but there is no location in the health care,
16 no space, so we have to discharge somebody to get the
17 inpatients, the patients to the health care. There is
18 a big demand.
19 Q. You have to prioritise those that have stayed?
20 A. There is quite a demand for the inpatient unit. This is
21 overflow so we have to get this inmate, we don't know
22 about him.
23 Q. Mr D was one of those that was prioritised because he
24 stayed in the health care centre?
25 A. There are five people I've seen. There were two in R1,

1 two in R2 and one in ward 3 --
2 Q. Let's focus on Mr D if we may. He was prioritised to
3 the extent he was located in the health care centre.
4 Yes?
5 A. Prioritised in the sense depending on whether there was
6 a bed available in the health care centre --
7 THE CHAIRMAN: I think we need to take a break. We will
8 take five minutes.
9 (12.40 pm)
10 (A short break)
11 (12.45 pm)
12 THE CHAIRMAN: Colleagues, we will resume there. We will
13 hope to conclude this morning's session within about 20
14 or 25 minutes, so we will run on and take lunch later if
15 that is acceptable to everybody. That should mean that
16 once we have completed, then you are released for the
17 afternoon.
18 A. Okay, thank you.
19 MR MORTON: Dr Ranaweera, if I could ask you, please, to
20 have in front of you volume 4, tab 1, paragraph 3.7.
21 Can I just give you a moment to read paragraph 3.7 to
22 yourself.
23 A. This one.
24 Q. This is Carole Draper's report, and at paragraph 3.7, by
25 reference to material that she had available to her, she

1 makes a reference to your examination on 3rd December.
2 Okay?
3 A. Yes.
4 Q. Then another document that we have from 3rd December is
5 the one we have already looked at for a different reason
6 which is your referral to the psychologist, which is in
7 bundle 1, tab 12, page 122. So if you could have that
8 available to you as well.
9 Now, and of course you also have the diary that we
10 were talking about just before the break.
11 So what we know for sure is this, isn't it, that on
12 3rd December you referred Mr D both to the psychologist
13 and a psychiatrist?
14 A. Yes.
15 Q. You, in your note in the reference to the psychologist,
16 you have referred to a past history of mental illness
17 query diagnosis?
18 A. Yes.
19 Q. Does that indicate that this was the sort of case where
20 you would have been particularly interested in having
21 any past history or past records, either from other
22 psychiatric assessments or from a GP or something of
23 that nature?
24 A. Yes.
25 Q. Do you think you would have taken steps to try and

1 obtain them in relation to Mr D?

2 A. Yes, as I told you before, I can't remember him at all,

3 but usually my practice is even now, I mean if I see or

4 assess somebody like D, I would make sure, tried to get

5 all the information available from the outside sources

6 for the previous psychiatric or medical information.

7 Q. Now, if Mr D was seen by a psychologist, we know he was

8 seen by a psychologist, Dr Halsey, and Dr Halsey

9 subsequently sent you a letter, which is at page 124;

10 would the psychologist make an entry, him or herself in

11 the IMR?

12 A. They usually do, yes.

13 Q. So from the psychologist's point of view, what would you

14 normally expect; have I got this right, you would expect

15 an entry in the IMR and the sort of letter we see here

16 from Dr Halsey, was that usually what happened, you

17 would have some sort of written report after the event?

18 A. I think depending on, like, even this one, it is written

19 on 25th January, and there is a delay for the typing and

20 it takes time for that one, but he would have written in

21 the IMR if it was available, and also if there is any

22 concerns, sometimes he would discuss with either the SMO

23 or with the doctor, allocated doctor or with the nursing

24 staff, whoever, in the health care team, he would

25 discuss.

1 Q. So you would know, you as the patient's doctor would
2 know that that examination has taken place; and you
3 would know either from the IMR, and/or from any
4 discussions with the doctor, and/or later from a letter,
5 what the view of that specialist was?
6 A. Yes, because once they assessed, as I told you, he would
7 have discussed with us if there is a particular concern,
8 or in the IMR he will record, which we will note when we
9 read the IMR, and also at the case conference, the twice
10 a week case conference, we would have noted whatever the
11 information.
12 Q. Now, similarly if a patient is seen by one of the
13 visiting psychiatrists, would that result in an entry
14 being made in the IMR?
15 A. Yes.
16 Q. Always?
17 A. Yes, if the psychiatrist had seen -- if they make an
18 entry in the IMR at the same time, sometimes you cannot
19 find the IMR as well, not if it goes to court or
20 sometimes if they go to the clinic it doesn't, it won't
21 go back to the same place where it should be, so in that
22 case sometimes we have to write on a continuation sheet.
23 Q. On a what?
24 A. It is called a continuation sheet and we write there
25 "IMR not available", and put the date and we make an

1 entry.

2 THE CHAIRMAN: Then that sheet would then be inserted in the

3 IMR when it turned up.

4 A. In the IMR, yes.

5 MR MORTON: Does it sometimes happen that the psychiatrist

6 would also write a letter after the event, after the

7 examination setting out their view, or not?

8 A. I can't remember whether it was for everybody.

9 Sometimes if they ask for a psychiatric report for the

10 court or something, I can't remember whether we wrote in

11 the report, not from the general psychiatrist, they

12 don't provide a report, if you ask for emergency

13 assessment, even for the forensic psychiatrist,

14 sometimes we get the report, I can't remember whether we

15 get each and every assessment, you know, unless it is

16 relevant.

17 Q. Now, what we know about Mr D, so far as we are able to

18 tell, is that he was referred to a psychiatrist on

19 a number of occasions and I can take you through them if

20 that would help you, but it does appear to have happened

21 on a number of occasions and Carole Draper certainly

22 suggests from her examination of the material that was

23 available to her, that he was never actually seen by

24 a psychiatrist between 30th November and 27th December.

25 Could you account for that, if that is right, if he

1 had not been seen, are you able to account for that?
2 A. First of all, I don't agree with Carole Draper's report
3 as I told you before. She never interviewed me, and
4 I don't know even Dr Yisa, as he mentioned yesterday,
5 when she interviewed Dr Yisa, even he has not seen the
6 IMR so I don't know from where she got all this
7 information and who read the IMR with her, like if he
8 was seen by -- I know he was waiting to see
9 Dr Akinkumni, by reading this, he was twice put in his
10 list on the 5th and on the 19th, I think, but he was not
11 seen. That doesn't mean that he wouldn't have been seen
12 by other psychiatrists, because the way we were working,
13 we were reviewing them daily and also at the ward round
14 we find out, there is quite a lot of safety netting was
15 in place. So he would have been, by reading all the
16 information available now, the way he was behaving, the
17 problem with his self harm and sometimes violent
18 behaviour and self harm risk, to take into all that
19 account, I'm very surprised if he was not seen by
20 a psychiatrist. I'm sure, with my experience, working
21 in the health care centre, if we had that specifically,
22 one of my patients, I would have rung up the
23 psychiatrist, usually like Dr Hadjiof or Dr Hurst.
24 Q. Mr D was one of your patients?
25 A. Yes, that is what I'm telling. If he was my patient

1 I would have treated him the same as I would have
2 treated all the other patients under my care, because
3 I would have made sure with all the information, that
4 sort of information available, he would have put in
5 front a psychiatrist while awaiting for this
6 Dr Akinkumni. I don't know why -- he was put in the
7 list. That doesn't mean that he cannot see any other
8 psychiatrist, especially if we had the medication --
9 Q. A little bit slower?
10 A. I'm sure he would have been seen by a psychiatrist, that
11 is my opinion, because one thing, with that sort of
12 thing we need to have an opinion from a psychiatrist
13 rather than just managing him day-to-day in the
14 health care. And also with his -- with the, I mean,
15 the -- he needs to be assessed by a psychiatrist, one
16 thing because of his self harm or behaviour, and also we
17 were concerned about, you know, he is not only self harm
18 to himself, he was harm to -- he was a risk to the other
19 people as well. There was one adjudication form. He
20 tried to hit that chair to the nurse as well, abusive,
21 so he needs to be assessed by a psychiatrist, so in my
22 experience, working in the health care centre, I'm sure
23 he would have been seen by a psychiatrist, because
24 Dr Hadjiof and Dr Hurst, they were available most of the
25 week, most of the days.

1 Q. Thank you. If he had been seen by a psychiatrist, it is
2 clear that that would have been in the inmate medical
3 record. That would have been recorded in the inmate
4 medical record?
5 A. Yes, it would have been --
6 Q. Sorry?
7 A. It would have been entered if Dr Hadjiof or Dr Hurst, if
8 they have assessed him, it is not page and page --
9 Q. I think we have the point, but there would have been an
10 entry?
11 A. Entered in the IMR, yes, if it was available when the
12 psychiatrist had seen him.
13 Q. If it was not available, there would have been
14 a separate continuation sheet?
15 A. They would have written in the continuation sheet, yes.
16 Q. So it would have been apparent at your case reviews or
17 on your ward rounds that Mr D had been seen by
18 a psychiatrist?
19 A. Yes.
20 Q. If he had already been seen by a psychiatrist and the
21 view was taken that he needed to be seen again?
22 A. Yes.
23 Q. Would it simply have been noted as a referral to
24 a psychiatrist in the later referrals, or would there
25 have been something more specific, like "re-refer" or

1 "refer again", or "to be seen again by doctor X",
2 something of that nature, or not?
3 A. Unfortunately, if I had the IMR I would have given you
4 a correct answer to this one, exact answer, but the
5 thing is, referred to psychiatrist, whatever the
6 information from Carole Draper's report, doesn't mean
7 anything to me, because what exactly are the
8 circumstances, why we had to refer to a psychiatrist
9 again.
10 Q. Can you focus on my question, please, Dr Ranaweera?
11 A. Yes.
12 Q. I'm assuming now that Mr D has been referred to
13 a psychiatrist and he has been seen by a psychiatrist?
14 A. Yes.
15 Q. But the view is taken that he needs to be seen again.
16 How would that be expressed, do you think, in the
17 subsequent referral?
18 A. Because if, while in the, during their stay in the
19 health care centre or in the prison, I mean the
20 psychiatrist not only see once, sometimes they had to
21 review several times, and the circumstance change,
22 sometimes the mental state of the patient, he is quiet
23 and no problem, but all of a sudden he tried to hang
24 himself, and we had quite a serious self harm or risk to
25 the others; the mental state, the change -- the

1 circumstances change, so he needs to be assessed by
2 a psychiatrist again, rather than just seen by a doctor,
3 so it is important that he should be assessed by
4 a psychiatrist, and also while waiting to be seen by
5 whoever the allocated psychiatrist, if he is seen by
6 Dr Hadjiof or Dr Hurst, that doesn't mean that we will
7 take his name away from the psychiatrist who is supposed
8 to do a full assessment.
9 Q. In the record, for example, of the case conference in
10 the 2052SH, would it be apparent to anybody reading that
11 that Mr D had been seen by a psychiatrist, and it was
12 thought he needed to be seen again?
13 A. It would have been documented in the IMR.
14 Q. What about the 2052?
15 A. 2052, if he was seen by a psychiatrist we would have
16 documented, but more detail, we always document a lot of
17 things in detail in this IMR.
18 Q. Can I just be clear about this: would you expect that if
19 he had been seen by a psychiatrist that the fact that he
20 had been seen would also have been recorded in the 2052?
21 A. Yes, I think it would have, as part of the assessment.
22 Q. And the 2052 also has a record of the case reviews.
23 Shall we just have a look so we can see what I have in
24 mind, if you would have a look at bundle 8. Tab 8.
25 Have a look for example at page 10. These forms

1 presumably were completed for each case review?

2 A. Yes.

3 Q. My question is this: would it be apparent to somebody

4 reading, would you expect it to be apparent to somebody

5 reading these documents, looking at a history of the

6 case reviews, that somebody had been seen by

7 a psychiatrist and needed to be seen again?

8 A. Yes, it would have been documented for -- I mean,

9 assessed by psychiatrist for review, it would say review

10 by the psychiatrist or the name of the person, yes, it

11 would have been documented.

12 And the other one, discharge report, number 12, that

13 2052, if they discharge from the health care centre,

14 sometimes if they are quite settled, we would have

15 discharged them to the ordinary location. That does not

16 mean that if you are still awaiting to be seen by

17 a psychiatrist, recommendation and management you have

18 to write there, for review by the psychiatrist and for

19 review by the psychologist.

20 Q. Just wait there a moment, because I think I may have

21 come to the end.

22 Sorry, there is one other document which Mr Eadie

23 has mentioned to me now on three occasions and I'm sorry

24 to have forgotten it. Could you have a look, please, at

25 bundle 1, tab 1. To put into context, if you could look

1 first at page 9, this is an incident report relating to
2 Mr D and the events of 27th December. If you look over
3 the page at page 10, there is a list there of staff who
4 were present on the 27th at about 15.50 on R1 landing:
5 As you look down, I'll give you a moment to read the
6 list?
7 A. Yes, I read it, yes.
8 Q. You have read the list?
9 A. Yes.
10 Q. We can see a number of people listed there. Are any of
11 them nurses?
12 A. Yes, I mean this one is, I don't know who documented,
13 there is a list, it is written here, incident on 27th --
14 Q. My question is from that list --
15 A. Staff percentages, this is serious --
16 Q. Can you just answer the question, please. Are any of
17 those people listed nurses?
18 A. It says PSN.
19 Q. So that means?
20 A. Prison service nurses.
21 Q. So each person, there is one PSN, two PSNs and...
22 A. And two, they have mentioned R1 and where they have come
23 from, actually, maybe because this is a major incident,
24 the self harm, hotel 9 so a lot of the staff come from
25 everywhere, you know to attend to the incident, so they

1 have put R1, so I assume that means R1, Hayward,
2 Denpiece(?) and Rodriguez(?), R1, so it is assumed that
3 they were from R1. If you see then PSN Ansong, he is
4 one of the psychiatric background, he comes from John
5 Howard centre, Ansong, he is one of the psychiatric
6 trained --
7 Q. That is a he and he is a psychiatric nurse, did you say?
8 A. They are the nurses, you know, the --
9 Q. Slow down. Did you say that he is a psychiatric nurse?
10 A. I think he came from John Howard centre, you know, he
11 had gone back there --
12 Q. Then we can see two agency nurses listed as well?
13 A. Two agency nurses and Dr Khan, the medical officer,
14 Dr Kunwar, he was the locum doctor, maybe during that
15 time I was away, so there was a locum doctor.
16 Q. I think you were.
17 A. And PSN Smith, he is from central treatment, so that
18 means he is from outpatients, but by looking at it, R1,
19 so that means the other people, they would have been
20 working there.
21 Q. Can I just ask you another point, when you conducted
22 your regular, what I was calling a ward round, when you
23 go round each day and see people, does that necessarily
24 result in an entry in the IMR as well? So if you go and
25 see somebody but you don't do anything, you don't

1 prescribe anything, you don't carry out any particular
2 assessment, would that nevertheless be recorded in the
3 IMR that you had seen somebody?
4 A. Yes, yes.
5 Q. So how did that work, then? Did you walk round with
6 a copy of all of the IMRs for each of your patients, or
7 did you then go back to the office and write up in the
8 IMRs?
9 A. Because we will, in the inpatients, the new patients
10 when we do the clerking, we have to take the IMR and
11 take them to a consultation room; if it is my patient,
12 normally we know who are the patients, so sometimes we
13 may see them in their cell or sometime we may see them
14 in the clinic --
15 Q. Every day, you go round and see your own patients?
16 A. Yes.
17 Q. My question is, do you walk around with the IMR for each
18 of your patients?
19 A. Sometimes we will see them in interview, the
20 nurses' station was just there, so it is easy for --
21 Q. I want to be quite clear to make sure that I have
22 understood; even if you didn't make any particular
23 diagnosis or any particular prescription, you might only
24 have said hello to somebody, would you still record that
25 in the IMR?

1 A. We will say stable.

2 Q. To say that you have seen them?

3 A. We will say stable, if there are no problems, stable we

4 record, yes.

5 Q. But it would still be recorded?

6 A. Yes.

7 Q. The reason that I ask you that question, is this -- and

8 I understand the disadvantage that we are all at in not

9 having the IMR -- could you have a look at

10 Carole Draper's report, please, which is bundle 4,

11 paragraph 6.10.1?

12 A. Yes.

13 Q. I'll just give you a a moment to read that paragraph to

14 yourself, 6.10.1. (Pause)

15 You can see the question I'm going to ask you.

16 Towards the end of that paragraph, she says:

17 "Although he appeared to settle in his later days in

18 health care, it should be noted that Mr D was not seen

19 by a doctor from the 18th to 27th December, or if he

20 was, there was not an entry made in his IMR."

21 A. I wouldn't --

22 Q. Can you explain or help with that?

23 A. As I told you, I'm repeating the same thing; I can't

24 comment on a report, somebody who I have never seen or

25 who never interviewed. If she had seen me during that

1 time, if I had the IMR I can comment on this, and I
2 wouldn't agree with this, how can, if somebody is in the
3 inpatient unit, not seen by a doctor, no, I wouldn't
4 agree with that.
5 Q. If he had been seen by a doctor, you would have expected
6 that to be recorded?
7 A. As I told you before, the IMR, because we have the
8 record-keeping like Dr Yisa told you yesterday, we have
9 a problem with the record-keeping, the IMR disappearing,
10 so I don't know what she had seen, if she had seen,
11 I don't know what she had seen, whether the IMR or
12 pieces of IMR, I'm not sure, or whether she had seen the
13 IMR, I'm not sure, but the health care, if it is my
14 patient, I can't comment up to the 27th, because I've
15 been away from the 25th. That doesn't mean that the
16 work stopped there. If I'm away there is another doctor
17 who is covering a bank holiday period, weekends, there
18 is on-call doctors. They don't automatically document
19 everything like the day-to-day doctor, but if there is
20 any incident they will document, but the weekdays, we
21 would have documented whatever we do, so I wouldn't
22 agree with this comment.
23 MR MORTON: Thank you, Dr Ranaweera.
24 Questioned by THE CHAIRMAN
25 THE CHAIRMAN: I just have one question that follows on from

1 that. Let us assume for some reason or another, the IMR
2 was not available and there was an interaction between
3 a member of medical staff and Mr D and it was recorded
4 on a continuation sheet. Where were these continuation
5 sheets kept until the IMR turned up?
6 A. For the inpatient one, because they had the trolley, the
7 IMR trolley in the IMR where it should be, while they
8 are in the health care, it was kept in the R1 patients
9 in the R1 landing, and for the R2 it was in the R2
10 landing.
11 THE CHAIRMAN: So could there be lots of these continuation
12 sheets, lying on top of the other?
13 A. His name, where it should be, the IMR, if there is no
14 IMR, sometimes when it goes to the court we cannot find,
15 if it goes to the court or sometimes if it is taken to
16 the clinic, it depends on the shortage of staff as well,
17 depending on whoever take, whether it comes back to the
18 same place; sometimes you cannot find where to locate
19 the IMR.
20 THE CHAIRMAN: Did you ever come across an occasion when
21 continuation sheets went missing?
22 A. That is, I mean unless they were filed, you know,
23 because once they have the continuation sheet, go to the
24 record room and the record IMR room and they are
25 supposed to, the person who was in there, they are

1 supposed to file, there were quite a lot of continuation
2 sheets as well as the treatment cards, and everything
3 should be filed, but there is only one person working
4 and there is quite a lot of things for file, you know,
5 there was a problem about filing.
6 THE CHAIRMAN: Thank you very much. Those are my questions,
7 I want to confirm that Ms Stern and Mr Eadie are
8 content.
9 MR EADIE: Yes, thank you very much.
10 A. As we told you before, there was quite a lot of shortage
11 of staff. We had quite a lot of problems in the
12 circumstances but we tried to manage, to do the best of
13 our capability to look after the inmates while they are
14 there. That is what I told you like before, if he is my
15 patient, I would have taken all my care to make sure
16 that although he was not seen by Dr Akinkumni, even I'm
17 not sure if he was seen, he would have been seen by
18 a psychiatrist during his stay, because it is very
19 unusual for somebody with that self harm and all that
20 behaviour problem not seen by a psychiatrist, which will
21 help for him as well as for management.
22 THE CHAIRMAN: Thank you for that. I just wanted to confirm
23 that Ms Stern is content.
24 MS STERN: I'm just checking.
25 THE CHAIRMAN: Of course. (Pause)

1 MS STERN: We are okay.

2 THE CHAIRMAN: Thank you for that. Thank you all this
3 morning and thank you particularly to Dr Ranaweera, and
4 I apologise to every one that we have run over in to
5 lunch. I think I'm right in saying that Dr Halsey is
6 not actually anticipated until 2.00 pm and as we have
7 run over, I suggest that we reconvene, shall we say, at
8 2.10. Thank you.

9 (The witness withdrew)

10 (1.15 pm)

11 (The short adjournment)

12 (2.10 pm)

13 DR ROBERT HALSEY (called)

14 THE CHAIRMAN: Thank you very much, every one. Good
15 afternoon, and we have now come to the last of,
16 I suppose what we have decided are our factual
17 witnesses. The two expert witnesses are tomorrow.
18 Dr Robert Halsey, I ought to declare an interest since
19 he and I are former colleagues on the parole board; I
20 have explained to Robert before we began the procedure
21 that we are going to follow, so I don't need to repeat
22 that. Are you content for us to proceed?

23 A. I am, yes.

24 THE CHAIRMAN: In which case I will ask Mr Morton to begin.

25

1 Questioned by MR MORTON
2 MR MORTON: Good afternoon, Dr Halsey.
3 A. Good afternoon.
4 Q. I wondered if I could start by asking you to be shown
5 bundle 2, and in particular page 119 of bundle 2.
6 This is headed, Dr Halsey, as the summary of
7 a meeting between you and Carole Draper. Perhaps not
8 headed as that, but that is what it is. It is a meeting
9 on 7th May 2002. It is not signed by you, and it is not
10 immediately apparent whether you have seen it before.
11 Have you in fact seen it before?
12 A. I have seen it before, yes.
13 Q. Accepting of course that it is a summary, is it accurate
14 so far as it goes, as summarising the meeting that you
15 had with Carole Draper?
16 A. Yes, I believe it is, yes.
17 Q. Then if you could go over the page, please, to page 125,
18 that is the first page of an interview that took place
19 on 8th September 2006 between you and Mr Shaw, and have
20 you had a chance to read that recently?
21 A. Yes.
22 Q. Is it an accurate record, so far as you can recollect,
23 of the conversation that you had with Mr Shaw?
24 A. Yes, it is.
25 Q. Thank you very much indeed. Now, you were first

1 interviewed by Carole Draper in May 2002. Was that the
2 first time you were asked about your dealings with Mr D?
3 A. Yes.
4 Q. So that was some five months or so after you had seen
5 him, and I think it is right to say that at that stage,
6 after five months, you didn't have any clear
7 recollection of him?
8 A. No, I had only met him on one occasion and he didn't
9 stand out in my memory in any particular way.
10 Q. Thank you. He was referred to you, if you could just
11 have a look at page 119, the second paragraph of the
12 summary, you were explaining the process of referrals,
13 and you said that the system now, that in May 2002,
14 involved a full written referral by the department in
15 Pentonville. That was after the introduction of
16 a system by Tony Madden. But this system was not in
17 place at the time Mr D was referred to you. We know in
18 fact that there was a written referral to you in
19 relation to Mr D. If you could be shown, please,
20 bundle 1, tab 12-page 122.
21 I wonder if you could just explain: although
22 written, this was still a referral under the old system,
23 was it?
24 A. It is very difficult to recall. The change to the
25 system which occurred, which I think I'm referring to on

1 page 119, was that rather than the referrals being made
2 directly from the medical officers, such as
3 Dr Ranaweera, to us as psychologists, the change that
4 occurred was that they then went via the in-reach team
5 which was headed by Tony Madden.
6 This referral, on page 122, as far as I recall was
7 directly from Dr Ranaweera to us, without going via the
8 in-reach team so it looks to me that this was under the
9 old system.
10 Q. It is signed at the bottom, we can see "referred by
11 Dr Ranaweera" on the last line.
12 Since I'm asking you about it, let me just stay on
13 the point at the moment, you saw -- I'm coming back to
14 that, sorry, to that point in a moment.
15 So under the old system, the referral was made,
16 plainly we see Dr Ranaweera writes out the referral
17 form, and I think you tell us that she left that in
18 a pigeonhole or something like that which you collected?
19 A. That is correct.
20 Q. No doubt together with all the other referrals?
21 A. That is right.
22 Q. Was there any means whereby the referrals could be
23 prioritised; was that a matter for you to consider or
24 for the referring doctor to consider, or were people
25 just seen in order, in turn?

1 A. It was very difficult to prioritise. The occasions when
2 we did do that was rarely, if the referring doctor made
3 a special case, usually a face-to-face meeting, and
4 would put in a special plea for someone. But usually
5 that didn't occur and we simply had the written
6 information such as this that is recorded on page 122.
7 Q. In terms of the time from referral to seeing somebody,
8 we can see that the referral was acknowledged the next
9 day. There is a letter sent in your name at page 123.
10 A. Yes.
11 Q. That says, we see in the second sentence:
12 "It is intended that most referrals will be seen
13 within one month of the date received."
14 That has the ring of a sort of standard response
15 about it, is that fair or not?
16 A. This was a letter that we sent out to every referral
17 that we received.
18 Q. In relation only to referrals from the prison, or would
19 this be in relation to any referral from a GP within the
20 NHS?
21 A. No, this was a set-up, a system that we had created to
22 address the prison, yes.
23 Q. So the expectation was that people would be seen within
24 a month, might be sooner, as it was in this case, but
25 within a month?

1 A. Yes, we hoped to be able to see people in a month, but
2 we didn't always. We weren't always able to make that
3 time period.
4 Q. Sometimes it could be longer?
5 A. Sometimes it could be longer, yes.
6 Q. Could you just give us a feel for how that compares with
7 referrals that are made to you within the NHS. Is there
8 a similar period, a shorter period or a longer period,
9 would you say?
10 A. It is slightly difficult to compare, because in general
11 we don't accept referrals from GPs. The referrals that
12 we have are from secondary services, from the community
13 mental health teams. It is very rare that we would have
14 a referral from a GP. But the referrals that we have
15 from the community teams, we were usually able to see
16 within a few weeks of receiving them.
17 Q. It doesn't sound from what you are saying, but I don't
18 want to put words into your mouth, as if there is any
19 significant difference between the time from referral,
20 even if it is from a secondary referral level, so to
21 speak, to examination, is particularly different?
22 A. No, not particularly different, no.
23 Q. Now, we know in fact in this case that Mr D was seen by
24 you on 18th December. So that is after about two weeks
25 from date of referral. The fact that it was rather

1 quicker than the acknowledgment letter anticipated, does
2 that tell you anything about might there be any
3 particular reason for that?
4 A. It could have been that as I mentioned before, it could
5 have been that one of the doctors may have asked me
6 personally to see this particular individual. It may
7 have been that we didn't have a huge number of referrals
8 on our waiting list at that time. There is a number of
9 possibilities.
10 Q. The document itself is marked "urgent" but we see from
11 your interview, I think that that wasn't uncommon. In
12 fact quite the opposite; I think you say something like
13 90 per cent of the referrals are marked "urgent"?
14 A. Yes, I don't know if it was 90 per cent, but a large
15 number of the referrals were marked "urgent" and were
16 of, often, quite a similar nature, so they were urgent,
17 yes.
18 Q. So they were properly marked as "urgent", but the fact
19 is that lots of them were?
20 A. Absolutely.
21 Q. Prior to your meeting with somebody such as Mr D, and
22 I appreciate the difficulty with the passage of time and
23 not remembering him personally, but what was your
24 practice? Presumably you don't just meet somebody cold
25 without knowing something about them. What do you do to

1 go about preparing for meeting people?

2 A. Well, the practice would be to attempt to find out as

3 much information as possible. As a minimum that would

4 entail having access to the medical record, the IMR.

5 There were unfortunately occasions when that didn't

6 happen. If there were cases which were considered very

7 urgent, but the IMR wasn't available, on certain

8 occasions we would in fact see people without seeing an

9 IMR. But that wasn't considered to be good practice.

10 Q. So that is the minimum.

11 A. Yes.

12 Q. Over and above that, would you look to see if there was

13 other material available?

14 A. Yes. Over and above that would usually involve

15 discussions with members of staff that know or knew the

16 individual. That could be prison officers, it could be

17 members of the medical team, to gain some more

18 background information.

19 Q. If the person you were seeing was on an open 2052SH, was

20 that a document that was available to you to see?

21 A. Sometimes.

22 Q. Routinely, or not?

23 A. Not routinely. Sometimes.

24 Q. I suspect I know the answer to this but I'll ask anyway.

25 The wing observation book, is that something that you

1 would ever have had access to or seen?
2 A. No, not particularly.
3 Q. No, so the IMR as a minimum, a 2052 possibly, but
4 I don't sense that that is something that would happen
5 very often?
6 A. Sometimes.
7 Q. What about sort of the medical management plan, the
8 nursing plans and things of that nature, was that
9 relevant to you or not?
10 A. If they were included in the IMR, then we would see
11 them.
12 Q. So far as the IMR is concerned, of course with somebody
13 who is a relatively new admission, that may not be
14 a very long document.
15 A. That is correct.
16 Q. Is it something that as a matter of course you would
17 read through in full or not?
18 A. Yes, that would be good practice to read it all before
19 seeing a person.
20 Q. The essence of your consultation with somebody such as
21 Mr D is a discussion, presumably, between the two of
22 you?
23 A. Yes.
24 Q. With you seeking to elicit from him information that
25 will enable you to form a judgment; is that right?

1 A. That is a part of the discussion, yes.
2 Q. Help us.
3 A. At an initial meeting, as I say I only had one meeting
4 with this particular individual, that initial meeting
5 would be focused upon information gathering. So it
6 would consist of a number of questions from me towards
7 him, trying to gain quite detailed background
8 information in regards to his functioning and any
9 difficulties which he was experiencing. Those, the
10 particular contents of those questions would of course
11 depend on the nature of the referral and the nature of
12 the problem that was highlighted.
13 The other aspect of the assessments would be to try
14 to make or come to a judgment about the person's ability
15 to benefit from ongoing psychological work.
16 So it wasn't simply the content of the answers that
17 was of interest; it was also the way in which the person
18 responded to being asked questions and how they engaged
19 with that process.
20 Q. Looking at the referral that was made to you, back in
21 bundle 1 at tab 12, page 122. I'll just give you
22 a moment to read it. (Pause)
23 A. Yes.
24 Q. I assume you can read Dr Ranaweera's handwriting. If
25 not we --

1 A. I'm more practiced in doing so.

2 Q. Yes, quite. What did you take from that as being the
3 nature of the problem highlighted, which I think was the
4 expression you used a moment ago?

5 A. As with many of the cases which were referred to us,
6 what stands out from the referral is that this is a man
7 with complex needs which are not easily definable or
8 have been assessed in a definitive way at that point,
9 because there are at least three or four separate
10 problems highlighted.

11 Q. Just help us, from your point of view, what are those
12 problems that you refer to?

13 A. Well, they are listed. Number 1 is alcohol abuse and
14 number 2 is a past history of mental illness, with
15 a question mark diagnosis, and it says that he has been
16 referred to St Clement's hospital in the past. There is
17 a history of self harm plus, which means a high degree
18 of self harm; he is on a 2052SH which was the self harm
19 monitoring and he has relationship problems.

20 Q. It is that last point that is followed by an arrow, "for
21 urgent attention clinical psychologist", for
22 consultation, I think. Did you take that to mean --
23 does that relate to the relationship problem or is it
24 the totality.

25 A. I think the arrow is -- clinical psychologist for

1 counselling is my reading of that, but I think the that
2 last point is in reference to the whole, or all of the
3 problems in totum, not the last one.
4 Q. How long, obviously there is no simple answer to this,
5 but in general, how long would your assessment take or
6 your time with the inmate take? It doesn't sound like
7 a quick process really?
8 A. No. The assessment would be spread over several
9 sessions to have a complete assessment.
10 Q. Your initial assessment, do you sort of allocate 10
11 minutes or 15 minutes, an hour, or two hours for each
12 person, or how does it work when you first see them?
13 A. Yes, we tended to see people for about 45 minutes at
14 a time, yes.
15 Q. As a result of that, let's take an initial consultation,
16 would you record the fact of that consultation and any
17 conclusions anywhere?
18 A. Yes. It would be recorded in the IMR and depending upon
19 other factors, we would decide when to write a letter,
20 a formal letter detailing the outcome of the assessment.
21 Q. Was that something that you did as a matter of routine,
22 that there would always be a letter sent following the
23 consultation, or were there some cases where that didn't
24 happen or it wasn't necessary?
25 A. I think in just about every single case we sent a letter

1 following the completion of the assessment.
2 Q. When you say "the completion of the assessment", do you
3 mean following the initial first assessment, or do you
4 mean the assessment after a number of sessions?
5 A. The latter.
6 Q. In this case we know from page 124 that you sent
7 a letter dated 25th January 2002 to Dr Ranawerra,
8 referring back to the assessment on 18th December but
9 I'll give you a chance to read the whole letter in
10 a moment, but it is apparent from over the page at 125
11 that you knew by the time you wrote this letter that he
12 had been transferred to the Royal Free?
13 A. Yes.
14 Q. First of all, can I just give you a chance to read
15 through the letter to yourself, so you can see what is
16 said.
17 A. Yes.
18 Q. Is there any particular reason why a letter was sent in
19 this case following the initial assessment only?
20 A. Yes. Because effectively this closed the case.
21 Q. He having been transferred?
22 A. Yes.
23 Q. To the Royal Free?
24 A. Yes.
25 Q. The matters that you set out in the letter -- I'm

1 looking in particular at page 124, the second, third,
2 fourth and fifth paragraphs, where you set out what you
3 were being told -- is that the sort of information that
4 you would have also recorded in the IMR?
5 A. Yes.
6 Q. It may be that your answer before last deals with the
7 point I'm about to raise, but the letter itself doesn't
8 suggest any particular form of treatment or any
9 follow-up or any course of action. Can you just explain
10 why?
11 A. Because the assessment wasn't complete. That is really
12 the answer.
13 Q. We know from a different source, which is the report
14 that Carole Draper prepared, that you referred
15 yourself -- sorry, I rephrase that, that you yourself
16 referred Mr D to a psychiatrist?
17 A. I've got no memory of that.
18 THE CHAIRMAN: Has Robert got the report in front of him, it
19 might be a kindness, so he can see what was written.
20 MR MORTON: It is bundle 4. If you have a look at
21 paragraph 3.2.1.
22 A. Yes.
23 Q. Just picking it up halfway through the paragraph, this
24 is Carole Draper's report so we are all clear:
25 "Mr Halsey said that he would see him again in the

1 New Year, but in the meantime Mr D required a thorough
2 psychiatric evaluation. He had listed him for the
3 visiting psychiatrist the following day but noted that
4 if he was not seen for any reason, then Mr D should be
5 included on the list of one of the visiting
6 psychiatrists at the earliest opportunity."
7 A. Yes.
8 Q. Was it unusual for you yourself to make a referral to
9 a psychiatrist or not?
10 A. It didn't happen all that often. It would -- I would do
11 so if there was a case about which I was concerned.
12 Yes, there was going to be a gap over the Christmas
13 period and I knew that I wouldn't be back into the
14 prison to see him. I obviously felt that it was
15 necessary for him to be seen by a psychiatrist and
16 I didn't want that period to be too long. But I guess
17 the fact that I've suggested it should be the following
18 day indicates that I did have concerns about this man
19 above and beyond the majority of people that I saw.
20 Q. Yes. As you say, the following day or failing that, at
21 the earliest opportunity?
22 A. Yes.
23 Q. I'll ask the question, although I anticipate I know the
24 answer. You cannot recall now, I'll rephrase that, can
25 you recall now any particular features of Mr D's

1 presentation to you that caused you to reach that
2 conclusion?
3 A. Well, his comments about his suicidal feelings.
4 Q. This suggests that you had listed him to be seen by the
5 visiting psychiatrist the following day; can you
6 recollect what that involved, what the system was, for
7 you making a referral?
8 A. There was at that time a person working in the admin
9 department of the health care centre who organised the
10 appointment system, and my assumption is that I will
11 have given the name to this admin person to be included
12 for the next day on the psychiatrists' list of patients
13 to see.
14 Q. Does it follow, it may not, from the fact that you made
15 that referral, that you thought that a psychiatric
16 assessment was at least as important as a psychological
17 assessment or more important?
18 A. No, it doesn't. That doesn't follow. The way that we
19 work is within multi-disciplinary teams. We have here
20 an example of a man who is clearly distressed, and was
21 causing a lot of difficulties for the prison in terms of
22 his management, and it wasn't particularly clear what
23 the nature of his problem was, and in order to help this
24 individual and help the prison to manage him, having
25 psychiatric colleagues who also are very experienced in

1 working with cases of that nature would be invaluable in
2 arriving at a management plan for this man.
3 Q. Were the psychiatrists that worked in the prison known
4 to you?
5 A. Yes.
6 Q. Again you may or may not be able to answer this: do you
7 think you would have referred him to any particular
8 named psychiatrist or simply to a psychiatrist?
9 A. That I can't answer with any degree of accuracy.
10 Q. Had he already been seen by a psychiatrist, would there
11 have been any reason for you to make a referral to be
12 seen again?
13 A. If I was particularly concerned about him, yes.
14 Q. Had he been seen by a psychiatrist, would that
15 necessarily have been apparent to you, or might there be
16 circumstances in which he might have been seen by
17 a psychiatrist since he had been in prison, but that
18 wasn't apparent?
19 A. If he had been seen by a psychiatrist, it would have
20 been written in the IMR.
21 Q. We have heard that sometimes when examinations take
22 place for whatever reason, the IMR is not immediately to
23 hand, and I think from what you have said yourself at
24 the beginning, that sometimes happens from your point of
25 view?

1 A. Yes.
2 Q. If that happened, you see someone, there is no IMR, so
3 there is no IMR for you to make an entry in, what was
4 your practice?
5 A. What would happen would be that there would be a written
6 summary which would be headed with the inmate's name,
7 the prison number, the date of birth, identifying
8 features, a record, which would then be placed in with
9 the medical records, so that when the IMR did
10 materialise, this written record would be inserted into
11 the medical record.
12 Q. Were there -- a difficult question to answer -- did you
13 ever come across occasions when you did have the IMR but
14 it wasn't complete or it later became apparent that it
15 wasn't complete, in other words, these additions and
16 things like it, hadn't been added in?
17 A. That is very difficult to say because of course --
18 Q. That is why I added "later became". I agree.
19 A. Yes. I don't know. One of the most difficult
20 situations was, of course, with people who were
21 frequently entering the prison and leaving, either on
22 short sentences or remand, because each time they
23 arrived at the prison, a new IMR would be started, and
24 all of the previous information would not be transferred
25 from the old IMR to the new IMR. That was one

1 particular problem that often occurred.
2 So we would know from our own personal experience of
3 having met that particular individual, that there was
4 other information, written information about that person
5 existing somewhere, but it wasn't in the IMR that we
6 had.
7 Q. If you had formed the view that Mr D was not genuine in
8 his presentation or was feigning symptoms, is that the
9 sort of thing that you would have recorded, do you
10 think, in the IMR and your letter that was sent later?
11 A. Yes. If I had suspicions about that I would make
12 a comment about that, yes.
13 Q. In your letter that we looked at a moment or two ago and
14 I asked you to read, of 25th January, I think it is fair
15 to say there is no suggestion there that that was a view
16 that you had reached about Mr D?
17 A. No.
18 Q. Does it follow that you had formed the view that he,
19 that there was no reason to think he was not genuine in
20 his presentation?
21 A. No. I assume that if it was the case that I had had
22 access to the IMR, that I would have been aware of the
23 problems, the self-harming behaviour that preceded the
24 referral, and the difficulties that he was encountering
25 within the prison.

1 Q. Does the fact that you referred him for a psychiatric
2 assessment the next day or as soon as possible indicate
3 of itself that you formed any view about the degree of
4 risk he posed to himself or to others?
5 A. Yes, I think it is fair to assume that those actions of
6 mine indicate that I felt that he was towards the higher
7 end of risk.
8 Q. Just so we are clear, to himself or to others, or both?
9 A. Particularly to himself.
10 Q. Having made that referral, again it may just be an
11 obvious question to you, but can just help us, what did
12 you expect to happen; first of all, you obviously had an
13 expectation he would be seen the next day or soon?
14 A. Yes.
15 Q. But beyond that what was your expectation, what would be
16 the consequence of him being seen by a psychiatrist?
17 A. That there would be an assessment, that following that
18 assessment the information, the view, the opinion of the
19 psychiatrist would help, together with once I had
20 completed my assessment of him, and the other
21 professionals involved, and together we would be able to
22 help the management of this individual whilst he
23 remained in prison.
24 Q. Had things not turned out as they did, how would that
25 have happened in practice? You say that together you

1 would have sought to help his management. Did that
2 involve as a matter of routine with inmates a meeting,
3 for example, between you and the psychiatrist and the
4 doctor or the nurses, or anything of that sort, or was
5 it done via the common point, so to speak, of the IMR?
6 A. There were a variety of ways in which that would happen.
7 There were not formal case reviews that I attended.
8 Certainly with my colleagues from the
9 North London Forensic Service, the psychiatric
10 colleagues who worked there, we would have opportunities
11 to meet and discuss, either within the prison or in the
12 hospital where we worked, we could communicate by
13 telephone, by email. So that represented a very easy
14 way of communicating our findings, and thinking about
15 management issues. It was not so easy with the
16 psychiatrists who were not part of that service, because
17 I only tended to see those individuals within the prison
18 on a face-to-face basis. I had their contact details
19 and I again could talk to them over the telephone or by
20 email.
21 But, yes, there were occasions when the sort of
22 point of communication was through the running record of
23 the IMR.
24 Q. What about contact with the doctor or doctors within the
25 prison responsible for looking after somebody? Did you

1 have much contact with them on a day-to-day or routine
2 basis?
3 A. Yes, yes, I did.
4 Q. That was done largely face-to-face when you were in the
5 prison or by telephone or what?
6 A. No, that was usually done face-to-face.
7 Q. One of the points you made, I think it was when you were
8 speaking to Carole Draper, at page 121 of bundle 2, was
9 that there was an absence of administrative support
10 provided to specialists such as yourself and that had to
11 be provided via Camlet Lodge.
12 Was that a problem? I mean, I can understand from
13 your point of view that it is rather frustrating, but
14 was it anything more than a frustration; was it actually
15 a problem in terms of your ability to carry out your
16 work or see that things were followed through?
17 A. Yes, it could be a bit of a hurdle, that was what we
18 found. Because for example the letters that followed
19 our consultation, ideally these should have been typed
20 up by the prison; we should have been able to dictate
21 letters whilst in the prison, leave them with the admin
22 staff there to be typed up, and then they could have
23 been put into the IMR in a sort of quick, easy and
24 seamless process. As it was, we had to use the
25 secretarial support from the hospital, Camlet Lodge. So

1 everything had to be -- notes of the meeting had to be
2 taken away, and typed up and then sent in, posted in to
3 the prison.
4 Q. But you tell us from your interview with Mr Shaw at
5 page 138 of that same bundle, the top answer on that
6 page, that the position improved following the
7 introduction of the mental health in-reach team?
8 A. Yes.
9 Q. And Mr Madden's appointment. More generally, did the
10 introduction of the mental health in-reach team from
11 your perspective improve the service that was provided
12 to inmates or detract from it?
13 A. I think it made quite a significant impact, an
14 improvement, yes.
15 Q. In what way?
16 A. Well, the difference was that Tony Madden and his team
17 were specialists in mental health, whereas the doctors
18 who previously we worked directly with, the primary care
19 doctors, were general doctors. They had to cover
20 a whole range of disorders, physical complaints, as well
21 as mental health problems. They were not specifically
22 trained in mental health problems, whereas as I say, the
23 in-reach team headed by Tony Madden were individuals who
24 had that specific training.
25 Q. Thank you. Then a series, if I may, of points in no

1 particular order.

2 At page 120 in bundle 2, which again is the summary

3 of the meeting with Carole Draper, you make the point

4 that the powers available to you in relation to

5 treatment of patients who were prisoners was more

6 limited than elsewhere.

7 What did you mean by that?

8 A. Could you point me to the particular --

9 Q. I knew you were going to say that, I'm just wondering if

10 my page reference is right. Bear with me a second.

11 A. Yes, I see, it is in the third paragraph.

12 Q. Thank you, sorry. Yes, I have not highlighted it in my

13 own copy. Thank you.

14 A. Yes.

15 "... if not in prison setting more damaged clientele

16 as their powers in relation to treatment were very much

17 more restrictive than those that operate in an RSU."

18 The point that I was referring to there was of

19 course that the Mental Health Act does not apply within

20 the prison setting, the prison environment, whereas it

21 does within the psychiatric hospital.

22 Q. And the significance of that from your point of view

23 was what?

24 A. That the whole framework in which we were working was

25 very different. The ability to treat someone in a wider

1 sense, not just in the psychological sense, was very
2 different in a prison setting. There had to be the
3 consent of the individual, whereas in a psychiatric
4 service of course if somebody is detained under section
5 the issues of consent are very different.
6 Q. Can I ask you about the working environment within the
7 health care centre as you saw it, because you come to
8 this as someone from the outside, so to speak, visiting
9 obviously often but with experience of working elsewhere
10 as well.
11 Of course we know the physical environment was far
12 from ideal. But I want to ask you not so much about
13 that but the sort of working environment and
14 relationships between people as you observed it and
15 experienced it. Was there, would you say, a good
16 working relationship so far as you were able to see
17 between the discipline officers on the health care wing,
18 or the health care centre and the nurses, for example?
19 A. On the whole, yes, it was a reasonably good
20 relationship, yes.
21 Q. And between the doctors and the nurses?
22 A. Yes, I think it was a reasonably good relationship.
23 There is a lot of stress, very difficult working
24 conditions, but all things considered I think people
25 treated each other with respect and the relationships

1 were functional.

2 Q. Would it be fair to say that you had some concerns about

3 the quality of the nursing care that was provided,

4 I don't say that meaning that nobody was providing good

5 nursing care, but that some of the nursing care was not

6 to your mind of a very high standard?

7 A. Well, there were problems with the particular aspects of

8 nursing care, in particular I suppose the use of agency

9 staff. That was a major problem.

10 Q. I don't mean to interrupt you if there are other points

11 that you want to make, but just so you know I'll ask you

12 in a moment why it was a problem. If you want the

13 identify what the issues were and then perhaps you could

14 explain why they were problems if they were.

15 A. Yes. Well, I think that was the main problem. Amongst

16 the permanent staff there were individuals who found it

17 more difficult to cope with the environment. There was

18 from time to time problems with sickness, high rates of

19 sickness absence, low staff morale, this is amongst the

20 permanent staff, but I think in general the permanent

21 staff who were there stayed because they could cope with

22 the difficulties. Those that couldn't cope did not

23 remain.

24 Q. In relation to the agency nurses, which is a particular

25 point that you raise as a problem, why did you see it as

1 a problem?
2 A. Well it is a systematic problem, I guess, not
3 necessarily particular to Pentonville prison, although
4 within the prison environment it is probably even worse,
5 exemplified in the fact that the agency staff did not
6 have access to keys; they couldn't move around the
7 prison in the way that was often required; they didn't
8 know the individuals with whom they were working. These
9 are not the sort of characteristics that are required in
10 the nursing function.
11 Q. Again it may be obvious to you, what is the significance
12 of that in relation to the care of people who have or
13 who had mental health issues?
14 A. Well, because a large part of providing care from
15 a nursing perspective is the development of the
16 relationship with the patient. And that of course takes
17 time to develop. Particularly with individuals who are
18 very distressed and may well have problems in developing
19 trusting relationships, it would not be expected for
20 those individuals to welcome new faces, new people who
21 they don't know, who are attempting to provide care to
22 them.
23 Q. One of the points you make in your interview with
24 Mr Shaw is that there were some chaotic and ad hoc
25 working practices. That is at page 136 of your

1 interview.

2 You identified something which I suspect is

3 something of a dilemma, because you also refer to

4 bureaucracy, but identify yourself that the bureaucracy

5 may have been necessary to try and overcome the chaotic

6 and ad hoc working practices, but what I want to ask you

7 is this: in your experience was that a problem, I will

8 rephrase that, did that impact upon the care that the

9 health care centre was able to provide for inmates on

10 that wing?

11 A. That is a very difficult question to answer. In an

12 ideal world we would want to be able to provide care on

13 an individualised case by case fully flexible basis,

14 which also adhered to sound principles. The

15 difficulty is of course that in a less than ideal

16 environment that can lead to bureaucracy and it can lead

17 to decisions being made without adherence to principles.

18 So instead of getting the best of both worlds we can end

19 up with the worst of both worlds.

20 Q. Can you just try and give us a feel for what that means

21 in practice in the context specifically of caring for

22 those with mental health issues in the

23 health care centre?

24 A. Well, the prison of course has a lot of rules about what

25 is allowed and what is not allowed.

1 The larger the institution, the more stress the
2 institution has to cope with, usually the more
3 inflexibly those rules are applied.
4 If there is a small unit, well staffed, with well
5 trained individuals, and a prisoner asks or makes
6 a request for something which is outside the normal
7 rules, that unit would have far greater flexibility, be
8 able to make a decision on a case by case basis.
9 Q. That sounds like something which would be true of any
10 prison that you went into by its very nature.
11 A. Yes.
12 Q. Is that a fair way of putting it?
13 A. Yes.
14 Q. So that is not something that would be unique to
15 Pentonville?
16 A. No, but the type of prison that Pentonville was, a local
17 prison, with a high remand population, with lots of
18 inmates coming and going on a daily basis, makes it very
19 different from the majority of prisons which have
20 a relatively fixed population. Pentonville and the
21 other local prisons don't work like that.
22 Q. There is much greater demand on the health care centre
23 no doubt?
24 A. Yes, it is a very much more stressful working
25 environment.

1 MR MORTON: Thank you very much. That is all I have to ask,
2 but there may be one or two more questions.
3 THE CHAIRMAN: If there are going to be some further
4 questions can I suggest that we break for ten minutes
5 and you have a chance for a word and then Dr Halsey can
6 have a break.
7 (3.05 pm)
8 (A short break)
9 (3.15 pm)
10 THE CHAIRMAN: I think we can recommence. Thank you very
11 much for waiting. There are just a small number of
12 additional questions.
13 MR MORTON: Dr Halsey, you will recall I was asking you
14 whether it was unusual for you yourself to refer an
15 inmate to see a psychiatrist and you indicated that it
16 was I think unusual. I have not got your precise words
17 to hand but we can look back at that if we need to. But
18 I wonder whether you could give us a feel for how
19 frequently or infrequently you made that sort of
20 referral either in terms of timescale or perhaps as
21 a proportion of the number of people that came to see
22 you. Can you give us a feel for that?
23 A. I would say relatively infrequently. I would hesitate
24 to put a figure, an exact number.
25 Q. How many times in a year would you do it, do you think,

1 or is it just not possible to quantify it in that way?
2 A. I really don't think I could give an accurate answer to
3 that, but it wasn't something which happened very often.
4 There would be particular circumstances in which that
5 might happen. With this case, I would be guessing, but
6 it may have been that I was aware that the psychiatric
7 referral had been made and the assessment hadn't yet
8 taken place and perhaps in addition to my concern over
9 the presentation perhaps I felt that my actions, in
10 addition to the referral from Dr Ranaweera, may have
11 assisted in enabling that assessment to take place.
12 That would be one sort of example why I might have
13 acted in that way.
14 Q. Having made that referral you will recall I asked what
15 you would have expected to happen in due course.
16 I think what you said was that you work as a team and
17 that you would expect collectively to put together
18 a plan for the management of somebody such as Mr D.
19 I wonder if I could just press you on that a little
20 bit further to get a feel from you as to what it was you
21 expected the psychiatrist to bring the bear on that
22 management. What sort of steps did you envisage or do
23 you envisage that the psychiatrist might be able to take
24 over and above those that are available to you or to the
25 doctors in the prison?

1 A. Well, those are two slightly separate things. Over and
2 above the doctors within the prison, of course, the
3 psychiatrists are specifically trained to assess and
4 diagnose the mental health issues of relevance.
5 So Mr D had a very complex presentation which was
6 difficult to assess, and was obviously quite a challenge
7 to the medical staff working within the prison.
8 So it wasn't clear to me what his diagnosis was. So
9 clearly I was hoping that having psychiatrists conduct
10 an assessment would help in terms of the diagnosis, and
11 to assess whether or not any medication would be helpful
12 in treating any condition which was felt to be apparent.
13 Q. So the essential starting point here, it seems obvious
14 I suppose, was there wasn't in fact a diagnosis and one
15 was needed insofar as that was going to be possible?
16 A. Yes, in order to construct a management plan we always
17 need to know what it is we are trying to manage. When
18 I saw Mr D I had no clear idea of what was underlying
19 his symptoms and I recorded the symptoms that I observed
20 and he reported to me. I had some ideas about what the
21 nature of his disorder was but I wasn't completely sure
22 of the diagnosis. I certainly wanted the ability to
23 discuss his case with other professionals trained in
24 mental health to arrive at that diagnosis.
25 Q. The diagnosis that you had in mind, was that

1 a psychiatric condition that required from your point of
2 view confirmation from a psychiatrist, can you recall,
3 or can you not now recall?
4 A. Sorry, a psychiatric diagnosis?
5 Q. You say that you had in mind a diagnosis but you
6 couldn't be sure.
7 A. Yes.
8 Q. Can I ask you what it was you had in mind?
9 A. I suspected that given the difficulties, the behavioural
10 difficulties, the instability, the volatility of the
11 behaviour, the self-harming behaviour, I suspected that
12 Mr D was suffering from a borderline emotionally
13 unstable personality disorder. Or at least that is what
14 I think that I would have had in mind at that time.
15 Q. Is that a condition which, if you had been sure, you
16 would yourself have been confident to diagnose, or is it
17 a condition which in any event you would refer or expect
18 a psychiatrist to diagnose?
19 A. The diagnosis is within the realm of medically trained
20 doctors; it is not something which psychologists have
21 specific training within. But, as I say, we work within
22 teams. We observe symptoms and we think about how those
23 symptoms relate to a particular diagnosis.
24 Q. From your experience that was a view that you had formed
25 but formally for it to be diagnosed that was a matter

1 for somebody else; is that a fair way of putting it or
2 not?
3 A. As I say, Mr D was complex and diagnosis is a very
4 difficult practice, and the sort of symptoms that he was
5 reporting are not found in just one disorder. There is
6 a considerable overlap. So it was -- is -- through
7 a process of repeated assessments and questioning and
8 observation that the diagnosis, the final diagnosis, is
9 finally reached.
10 Q. I have asked you about the sort of matters that you
11 would expect a psychiatrist to bring to bear on the
12 considerations that we are discussing, and you also made
13 the point earlier on that that would lead to
14 establishing a plan for his management.
15 A. Yes.
16 Q. Can you give a sense of the timescale that you might
17 expect it to take? Let's take Mr D. You have seen him
18 on the 18th December. You ask for him to be seen by
19 a psychiatrist the following day, or as soon as possible
20 after that. All things being well, how long would you
21 expect it to take for you and your colleagues to be in
22 a position to formulate this plan?
23 A. Well, the plan would evolve over time. It wouldn't be
24 the case that on day X there was no plan and on day Y
25 the final plan was in place. Parts of the plan would

1 develop over time. In most cases that would involve
2 liaison with the individual's GP or their community
3 mental health team, if one existed, to think about for
4 example whether or not this person is going to remain
5 within prison, whether or not we link with the external
6 agencies to think about what might be required when they
7 leave prison if they are on a short sentence or on
8 remand.
9 But over a timing of the first few weeks whilst
10 a person was in prison a plan would evolve, but then
11 would adapt and change as any developments arose.
12 Q. If the diagnosis that you had in mind turned out to be
13 correct, and you said that you suspected that Mr D was
14 suffering from a borderline emotionally unstable
15 personality disorder, what might that management plan
16 have consisted of so far as D was concerned; what impact
17 might it have had on him?
18 A. Well, the primary treatment would have been
19 psychological rather than psychiatric. Not to say that
20 he may not have been prescribed some form of medication,
21 but that on an ongoing weekly basis the psychologists
22 visiting the prison would have provided ongoing
23 treatment for him. That would be our role.
24 Q. In the form of what?
25 A. In the form of ongoing sessions to discuss the

1 difficulties that he was encountering and to try to use
2 psychological techniques, problem-solving, and to help
3 him to think of constructive ways to deal with the
4 problems as they arose rather than reverting to
5 self-harming behaviour.
6 Q. And then finally, Dr Halsey, the document I said that
7 I would ask you to look at, one of the features that you
8 identify at page 124 in the third paragraph was:
9 "He reported suffering from auditory hallucinations
10 in which he hears the noise of his ex-girlfriend telling
11 him to kill himself which he told me he had acted on in
12 the past, for example by throwing himself under a bus
13 and also jumping into the River Thames from
14 Woolwich Pier."
15 What significance if any did you attach to that
16 report by him of hearing voices telling him to kill
17 himself?
18 A. Well, it is obviously very worrying. That somebody has
19 acted as a result of experiencing hallucinations
20 previously puts them into a high risk category.
21 Obviously that is the reason why I listed it in my
22 record of what took place.
23 In terms of diagnosis, what we have here is
24 a psychotic symptom, that is how it would be termed, an
25 auditory hallucination, something which is unreal, which

1 to the subject appears to be real. It is that type of
2 symptom which I wanted to have the opportunity to
3 discuss with the psychiatrist. That is why I have
4 reported it in some detail so that the psychiatrist when
5 they go to see this man could ask him about that, gather
6 some more information, to help to arrive at a view as to
7 the nature of the disorder that we were dealing with.
8 MR MORTON: Thank you very much indeed. That is all I have
9 to ask Dr Halsey.
10 Questioned by THE CHAIRMAN
11 THE CHAIRMAN: Just a couple of questions, not to prolong
12 matters unreasonably. The first concerns record-keeping
13 within Pentonville.
14 When I interviewed you in September last year, and
15 again today, you have talked about records frequently
16 going missing. I just want to have a feel for what
17 "frequently" means. You were going into the prison
18 several times a week?
19 A. At least once or twice a week, yes.
20 THE CHAIRMAN: Would it be every time, once a week, once
21 a month that you would find records missing?
22 A. We would see on a daily basis perhaps five, six or seven
23 cases. It would be -- I'm just trying to think of the
24 correct wording, but if we had all of the IMRs available
25 for all of those consultations that wasn't something

1 which happened all that often.

2 THE CHAIRMAN: Putting it in another way, on most occasions
3 when you went in to see a number of patients you would
4 have ended up writing your findings down on either
5 a form or continuation sheet for the IMR or on
6 a separate piece of paper which in time you hoped would
7 be attached to the IMR?

8 A. That could happen. What is unusual about this case in
9 terms of record-keeping was this man was an inpatient in
10 the hospital. It was relatively less common for the
11 medical records to go missing for somebody who was
12 actually housed in the --

13 THE CHAIRMAN: That is an important distinction which I
14 should have drawn out from you.

15 A. Yes, because the fact that the person was a resident in
16 the hospital wing, the health care department, meant
17 that the record was in much more common usage, it would
18 be looked at, it would be a working document, rather
19 than somebody who was physically and mentally well but
20 that after an initial screen by a doctor would not have
21 much contact with the health care centre.

22 With Mr D we can imagine that there would have been
23 a large number of entries. He was seen by lots of
24 different people over time.

25 Physically, a physical environment, there were not

1 many places where that IMR could go. There were only
2 a few offices where the individuals who saw Mr D worked
3 and there was only one office where the records were
4 kept. It was much more common for records to go missing
5 for those individuals who had relatively little contact
6 and who were housed on the wings.
7 THE CHAIRMAN: Do you have any recollection when you were
8 interviewed by Carole Draper if she had the IMR or the
9 2052 with her when she conducted that interview?
10 A. I can't remember that, to be honest.
11 THE CHAIRMAN: My final question relates again to something
12 that you told me over a year ago, which was that
13 North London Forensic Service had lost its contract with
14 Pentonville and you were no longer working there.
15 I believe you said something to the effect that
16 psychological services for prisoners at Pentonville were
17 actually better in 2001, the period that we are
18 concerned with, than they were in 2006 when we spoke.
19 Has there been any improvement since then? Have you
20 got a contract with Pentonville now? Are you still
21 working with Pentonville?
22 A. No, there hasn't been any change since the time that
23 I spoke to you last. The North London Forensic Service
24 still maintains a presence within Pentonville. That is
25 by way of the forensic psychiatrists, my forensic

1 psychiatry colleagues. But there are no clinical
2 psychologists going into the prison on a regular basis
3 as there were back in 2001. The funding that was
4 available at that time and was stopped last year has not
5 been reinstated.
6 THE CHAIRMAN: Thank you very much for that.
7 MS STERN: I think we have one thing arising from the
8 answers just earlier if we can. (Pause)
9 THE CHAIRMAN: Keith, yes.
10 Further questioned by MR MORTON
11 MR MORTON: Dr Halsey, back to the letter that I've asked
12 you to look at, your letter at page 124. I took you to
13 the third paragraph referring to auditory
14 hallucinations. I didn't take you to the following
15 paragraph. Can I just ask you to look at that as well,
16 please. That reads:
17 "Mr D told me that he also suffers from nightmares
18 in which he hears people shouting at him. He said for
19 this reason he is frightened to sleep."
20 A. Yes.
21 Q. You have identified in relation to the auditory
22 hallucinations that that was a psychotic symptom?
23 A. Yes.
24 Q. Does that suggest whether taken with the second sentence
25 I've just read to you or on its own that this was a case

1 in which there might be a dual diagnosis of the
2 personality or behaviour disorder, borderline
3 personality disorder that you have identified, together
4 with the possibility of a mental illness or not?
5 A. Possibly.
6 Q. If there was such a diagnosis, whether taken together
7 with or separately, arising from those psychotic
8 symptoms, might that of itself have resulted in some
9 sort of medication being prescribed?
10 A. Possibly.
11 MR MORTON: I'm looking to see if that has covered the
12 point.
13 THE CHAIRMAN: Yes. I think that is as much as the witness
14 can reasonably be expected to answer on those particular
15 questions.
16 In that case I will now adjourn until tomorrow
17 morning. Thank you all very much and thank you to
18 Robert for joining us this afternoon, and thank you to
19 all for contributing.
20 We will meet again for what we assume will be the
21 final occasion at 10.30 tomorrow morning.
22 (3.40 pm)
23 (The witness withdrew)
24 (The Inquiry was adjourned until 10.30 am on Wednesday
25 21st November 2007)

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