

Prisons and Probation Ombudsman

Investigation no 01/2007

INVESTIGATION INTO THE ATTEMPTED SUICIDE OF 'D' WHILST IN  
CUSTODY AT HMP PENTONVILLE ON 27 DECEMBER 2001

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WITNESS STATEMENT OF PHOEBE CHIKUKU

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I, Phoebe Chikuku of *St Ann's Hospital, Downhills Ward, St Anne's Road, Tottenham, N15 3TH*, WILL SAY AS FOLLOWS:

1. I am a registered mental health nurse currently employed by the Barnet, Enfield and Haringey Primary Care Trust at St Ann's Hospital. I was the agency nurse employed to carry out the 15 minute documented observations in the healthcare centre at Her Majesty's Prison Pentonville ('HMP Pentonville') on 27 December 2001. I can remember some details about D and the incident but my memory is not at all clear now because it is so long ago. I am aware of the terms of reference of this investigation and am happy to assist the Ombudsman to investigate the facts and circumstances surrounding D's attempted suicide.

**Background and qualifications**

2. I studied for a three-year diploma in nursing at the Bell College in Dumfries in Scotland from September 1998 to June 2001. The first one and a half years of my training were in general nursing. I then chose to specialise in mental health

care during the second half of my training. After I graduated, I moved to London and became a registered mental health nurse. This means I was registered with the Nursing and Midwifery Council (NMC). I took up my current post, as a registered mental health nurse at St Ann's Hospital in summer 2001.

### **Agency work**

3. When I moved to London from Scotland I signed up with an agency to do temporary work. Unfortunately I cannot now remember which agency I joined and I am not sure whether it still exists. As I had a full time job at St Ann's hospital, I would only work occasional shifts for the agency. This would mean that I would fit the agency work around my full time job. I only ever worked at HMP Pentonville as an agency nurse. The agency would call me on an ad hoc basis and if I was free (for example, if I was on leave) I would undertake the odd shift at HMP Pentonville. I do not now remember exactly when I stopped working for HMP Pentonville as an agency nurse.

### **Healthcare at Pentonville in 2001**

4. As HMP Pentonville is the only prison that I have worked in, I cannot say how it compares to other prisons or whether the physical environment was different to any other prison healthcare centre. I cannot compare the working environment either. As it was such a long time ago, I cannot remember the names of the doctors, nurses, healthcare staff or prison officers that I used to work with but I recall that I got along with the staff at HMP Pentonville and I did not have any problems with the discipline or medical staff in the healthcare centre.

## **Training**

5. In 2001 my professional training was all still quite fresh in my mind because this was the year that I obtained my diploma and became a registered mental health nurse. Suicide and self-harm awareness were topics that we covered during my nursing training. We also learnt about the signs and symptoms of mental illness and mental health issues. The ability to be able to accurately diagnose a specific mental illness is the responsibility of the clinician (that is, the doctor or psychiatrist). It was not my role to diagnose patients. When I worked at HMP Pentonville I would keep an open mind about the patients and their conditions and I would use the risk assessments made by the doctors and nurses responsible for that patient's management. If I was concerned about a patient I would communicate my concerns to the doctors or nursing staff.
  
6. Before the agency sent me to HMP Pentonville, they explained to me what the job would entail and described how to go about doing the 15 minute observations and the one-to-one observations and how to use the self-harm at risk form ('F2052SH'). I did not have any formal training on this when I got to HMP Pentonville but I did not think that I really needed it. When you are doing observations, you just need to know about the prison environment and why the patient is on a particular level of observations so that you can decide how to interact with them. I knew that if I had any questions or concerns, I could always raise these with the nurse or doctor in charge.

## **Emergency Training**

7. I was given basic emergency training as part of my nursing diploma course. This included how to cut a patient down if you found them hanging. The agency also

told me what to do in case of an emergency whilst I was on duty at HMP Pentonville. This was really just to raise the alarm. I knew that if I raised the alarm then an emergency team would come. I did not have any ligature cutters with me when I worked at HMP Pentonville and I did not know where the anti ligature scissors were kept in the Healthcare Centre. As I was usually undertaking observations when I was at HMP Pentonville, I was not supposed to leave my area of work and I did not have keys to move around through the landings to fetch things. I understood that there was an Emergency Response Team, which would come if you pressed the alarm. The resuscitation team who came to help me on 27 December were very good and helped to save D's life.

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

8. It is hard to manage those at risk of suicide or self-harm, even if you are a registered mental nurse. This is because you can never really tell if someone is going to kill themselves unless they give you some clues. It is easier if you have been with a patient for a long time as you have built up a rapport with them and so it is easier to tell what their moods are and how they will react to certain things. If I was worried about one of my patients, I would let the nurse in charge know so that they could decide how best to manage them. The best course of action would not always have been to increase the level of observations. It is also true that if a patient is really determined to take his own life, he could do so, even whilst on constant observations.
  
9. To my mind, the most important thing when doing observations was to be able to interact with those at risk as much as possible and get them to talk about their issues. I found that some patients would be more open with me because I was an agency nurse but some would be less prepared to talk to me. It is normal that

some people feel more comfortable opening up to relative strangers whereas others will only talk to people who they know well.

10. I thought that the Listener scheme that operated at HMP Pentonville was quite good. If a patient wanted to see a listener I would let the nurse in charge (or healthcare officer) know. There was number that they would ring to request a listener. As the nurse in charge was in the office, they would make the call and then they would come and let me know if there was someone available and when they would be coming over. If one of the patients that I was watching was upset but did not want to talk to me about it, I would suggest that they might like to speak to a listener. Some times the patient would think that it was a good idea and sometimes they would not; so if they did not want to talk there was nothing you could do about this. On 27 December, if D had said that he did not want to talk to me, I would probably have asked him whether he wanted to see a listener; but I cannot now recall what actually happened with D.

### **Role and responsibilities**

11. As an agency nurse, I was asked to carry out a range of duties during my shifts at HMP Pentonville. Sometimes I would be asked to do 15 minute observations and sometimes I would go to the ward and look after 5-6 patients on open F2052SH forms. If I was in the ward, I would be watching the patients all of the time and making hourly entries into their forms. This would also involve reading and reviewing each patient's nursing care plans. Sometimes I would dispense medication the doctors had prescribed, or if needed, I would make a note of the doctors' diagnoses and risk assessments. We would document notes about how the patient was at the end of each shift and I think this was in the Inmate Medical Record ('IMR') but am not certain about this given the passage of time. This

would include matters like how the patient was eating or sleeping and how well he was interacting with others.

12. If I was doing the 15 minute observations, I would not have access to any of the patient's files as these were all in the office and I would not have time to go and look for the patient's notes. I would use the information that I was given during the nurses handovers to prepare me for how a patient was likely to behave when I saw them. Ultimately, you have to base your assessment of a patient on the person standing in front of you at the time of your observations, using your own judgement and by assessing their mood and behaviour.

### **Handovers**

13. I remember that when I went to HMP Pentonville, I would be given a handover at the beginning of my shift. This was when the senior nurse or healthcare officer would tell the staff about the status of each of the patients and then the staff would be told where they were going to be working during that shift. If I was being asked to cover the ward I would be given the IMR or care plans for the patients in the ward. If I was being asked to do the 15 minute observations, I would be given a clipboard with an observation sheet for each of the patients I was to look after and I would be given some details about them. The nurse or healthcare officer would say things like 'Mr X is depressed' or 'Mr Y had a bad night' or 'Mr Z has a history of self harm' so I would know what to look out for and how to approach my interactions with them. So if a patient was considered to be at risk of suicide or self-harm, this would be explained to me during the handover. However, if a patient was considered to be a high risk of suicide, he would likely have been in the ward or on one-to-one observations. I got the impression that D was a medium risk. He did not need to be under constant observation but he needed to

be seen and interacted with and that is why he was placed on 15 min documented watches.

14. At the end of my shift, I would report back to the nurse in charge and healthcare staff. I would bring any concerns I had about the patients I had been watching to the staff during the course of my shift but I would also highlight these to staff at the end of my shift too so that they could brief the next nurse who would be doing the 15 minute observations during the night.

## **Observations**

15. The nurses' office was in the middle of the healthcare landing. There were cells on either side of the landing. There would be maybe two or three patients on documented 15 minute observations on each side of the R1 landing. So I may have been observing around 6 patients in total. I used to do my observations at between 10-15 minute intervals and I would vary the order and timing of my observations so that they were not predictable for the patients. This means they were irregular checks but patients would be checked at least once every 15 minutes. Sometimes I was checking patients at shorter intervals, so nearly every ten minutes. I would walk around checking each patient and seeing whether they wanted to chat. If someone wanted me to sit and talk to them for a few minutes, I would make sure that the other patients were all right before going to sit down outside the patient's cell for a chat and I would also make sure this did not interfere with the observations that I needed to complete on my other patients. That way the other patients knew that I would be doing my next round again soon, but could not tell how soon I would be back. Doing my observations in this way meant patients would have less opportunity to try and self harm; but of

course if a patient was determined to self harm or commit suicide they could still do it.

16. If any of the patients I was observing said or did anything that concerned me, (for example, if they threatened to self harm), I would make a note of this on the documented watch sheet and would go and tell the nurse in charge or the senior officer. In case of an incident, I would raise the alarm, either by shouting or pressing the alarm bell, or sometimes by doing both of these things.

17. I was not responsible for making decisions about the most suitable level of observations for each patient. However, if for example, I was doing 15 minute observations on a patient and found that they were repeatedly trying to cut themselves or were threatening to self harm, I would recommend to the nurse in charge that the level of observations should be increased as they might be better supported on one to one observations. I cannot now remember whether I ever actually needed to do this during my time at HMP Pentonville.

18. I do not know whether a doctor had to authorise the level of watch for each patient or how exactly the process worked. However, if a decision was made to put someone on one to one observations then a nurse would have to be found to do the observations. This would often involve arranging for an agency nurse to come in and whilst that was being arranged HMP Pentonville would use their own staff to do the constant observations.

#### **Records and entries relating to D**

19. I would not have had access to D's medical records and I did not write in the Observation Book. I do not remember if I had carried out observations on D before or whether I was aware of his previous history of serious self-harm incidents. I have seen a copy of the healthcare Observation Book showing entries that were made in relation to D. I do not recall any of these incidents. When I was observing D, I did not make judgements about his condition. I simply carried out the observations that were required. As I said, if I was worried, I would report my concerns to the nurse in charge or senior officer so that they could decide whether to raise the level of observations. At the end of the day, doctors and nurses have to make judgment calls about the level of risk a patient poses and they work together as a team.

#### **D's suicide attempt**

20. I do not remember D but I do remember finding him hanging on the afternoon of 27 December 2001. I remember that I had quite a few patients on 15 minute documented observations on that day. I cannot now remember how many but I think it would have been between 4 and 6 patients. I cannot now recall what information was given to me during the morning handover about the patients I was looking after.

21. I remember that D kept covering his flap with newspaper during the course of the morning I had to keep going over and pushing it out with my pen. It was not uncommon for patients to do this when they wanted some privacy but I could not allow D to do it as I needed to be able to see what he was doing as he was on 15 minute documented observations.

22. I do not remember D going for the phone call but I do remember him coming back with an officer. I seem to remember that D appeared angry and upset when he came back from the call but I cannot be sure after such a long period of time. I do not remember clearly but I think that it was D's neighbour who told me that he had received some bad news and that his kids were going to be taken into care. I think that I asked D what had happened but he didn't want to tell me. The officers put him back into his cell.

23. I carried on with my observation rounds. I visited each of the patients on the 15 minute documented watch as usual. When I got to D's cell, it must have been some 10 mins or less from when he was returned from the phone call. I noticed that there was a newspaper blocking D's observation hatch. I remember that I called out his name. He did not answer so I pushed the newspaper away with my pen. I thought maybe he was sleeping because he did not answer me. When I looked in to the cell I couldn't see him on the bed. I looked up and saw that he was hanging from the light fitting. I shouted for help. as I did not have any keys to open his cell door. I cannot now remember if I also pressed the alarm on the wall. Even if I had had the keys to his cell, I would not have been able to support D to take his weight of the ligature or cut him down without help.

24. D had turned blue because he was not breathing. This image sticks in my mind because it was the first time that I had seen this happen. Thankfully, the emergency response team arrived really quickly. I thought that they were really brilliant. They entered the cell and cut D down almost immediately. I do not think that he could have been hanging for very long.

25. Looking at these events from now, it seems that the phone call was the trigger to make D attempt to take his life, but at that time, D did not give me any clues

about what he was going to do. He seemed angry and upset but did not say he was going to take his life and he didn't say anything else which would have alerted me to his intention. Everything seemed to happen so quickly. I cannot remember now exactly how long passed between D leaving his cell, having the phone call, coming back and then me finding him hanging. My only recollection is that it was all quite quick.

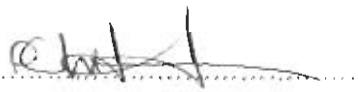
26. I stood outside D's cell in a state of shock. I had never seen anyone hanging before and so the image of D had a big impact on me. Someone took me aside and gave me some support. They talked to me and asked if I was all right. We talked for a little while and then they sent me home. I do not remember filling in an incident report form, but suppose this would have been done by the permanent members of staff. I had another shift at HMP Pentonville the next day. I did not want to do the 15 minute observations though, as I felt that every time I walked past D's cell I would remember what I had seen.

27. When I called my agency two days later, I was surprised to find that no one from HMP Pentonville had called them to let them know what had happened. When I told my agency, they offered me some follow up support but I did not need it as I had family around. Whenever I went in for a shift at HMP Pentonville, I would ask the nurses if there was any news on D's condition. I had understood that his condition had improved.

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

28. I do not know whether any changes were made to the policies and practise at HMP Pentonville following D's attempt. When it comes to assessing patients with mental health issues, every patient is different, so the important thing to my mind is there should not be a rigid process to be followed and that each patient should be treated as an individual. As an outsider, I could see that the staff at HMP Pentonville were dealing with some quite serious mental health issues on a daily basis. Perhaps some more detailed training might help them further understand the issues that patients in the healthcare centre are facing.

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

Signed.....  
Position.....RMN.....  
Date.....12/11/09.....