THE D INVESTIGATION

COUNSEL TO THE INVESTIGATION'S CLOSING SUBMISSIONS

INTRODUCTION

1. These Submissions should be read together with the Opening Statement dated 5 July 2007.

2. Under the procedures adopted, it has been the function of Counsel to the Investigation to seek to adduce evidence relevant to the issues the Chairman has been tasked to address. That was done in consultation with the Interested Parties to whom I am indebted for their assistance and co-operation.

3. To my mind the role of Counsel to the Investigation at this stage is limited. The conclusions to be drawn from the evidence are entirely a matter for the Chairman. It forms no part of function of Counsel to the Investigation to contend for or imply any particular conclusion.

4. It may, however, assist the Chairman if I set out below submissions in relation to the legal framework and identify what might be thought to be the central issues.

THE LEGAL FRAMEWORK

5. The general principles are clear. Both the common law and Article 2 impose upon the State a positive duty not to take life and to take appropriate steps to safe-guard life. The State owes a particular duty to those in its custody: not only must such people be protected against violence at the hands of agents of the State but they must also be protected against self-harm (see *Reeves v Commissioner of Police of*

the Metropolis [2000] 1 AC 360). The nature of that duty was succinctly identified by Lord Bingham in *R (Amin) v Home Secretary* [2004] 1 AC 653 at para 30 to be as follows:

"Reasonable care must be taken to safeguard their lives and persons against the risk of avoidable harm"

6. The purpose of this investigation is to comply with the State's procedural obligations under Article 2 to investigate cases where there is a breach of the substantive duty under Article 2 or reasonable grounds to suspect there has been such a breach. To comply with this procedural obligation the investigation must (amongst other things) be effective. In context, Lord Bingham explained in *Amin* that this means ensuring:

"so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others"[1]

7. Where someone dies or is injured in custody the burden is upon the State to provide a "satisfactory and convincing explanation" of what has happened. In *Salman v Turkey* (2000) EHRR 425 at paras 99 and 100 the ECtHR held:

"Persons in custody are in a vulnerable position and the authorities are under a duty to protect them. Consequently, where an individual is taken into police custody in good health and is injured on release, it is incumbent on the State to provide a plausible explanation of how those injuries were caused. The obligation on the authorities to account for the treatment of the individual in custody is particularly stringent where that individual dies …. Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries and death occurring during such detention. Indeed the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation".

[1] [2004] 1 AC 632 paragraph 32

8. In the circumstances of this case, the Secretary of State has accepted that:

> "… in combination (a) the circumstances surrounding D's attempted suicide, D being a prisoner who, it is accepted, was on 27 December 2001 known by the prison authorities to be a 'real and immediate suicide risk', (b) the seriousness of that incident and its consequences and (c) the existence of issues as to whether more could have been done to deal with the risk, triggered the implicit investigative obligation under Articles 2 and 3."[2]

THE CENTRAL ISSUES

9. There being no dispute that D was known by the authorities to be a real and immediate suicide risk, the evidence at the public hearings focussed upon the:

   (a) systems in place for ensuring the well being of those such as D at the prison; and

   (b) operation of those systems in relation to D and more generally the treatment of D throughout his short time at the prison.

10. The Investigation will wish to consider, in the light of the conclusions it draws from the facts in relation to these issues, the extent to which, if at all, any acts or omissions of the authorities contributed to the serious injury D inflicted upon himself and whether more ought reasonably to have been done to ensure his well being.

11. In considering these issues it is submitted that the Investigation should keep in mind that the conduct of individuals and of the authorities more generally should not be judged with the benefit of hindsight. The position when it comes to considering recommendations for the avoidance of similar events in the future is

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[2] See para 19 of the judgement of Munby J in the first instance decision giving rise to this Investigation: *R (On the Application of D) v Secretary of State for the Home Department* [2005] EWHA 728 (Admin)

different. In that context, the Investigation will by definition make recommendations based upon what is now known about the circumstances of this case.

12. Within the two broad themes referred to at paragraph 9 above, the Interested Parties have identified in their Submissions specific matters to which they draw the Chairman's attention and the conclusions they invite the Chairman to reach. I do not propose to comment directly upon those submissions or to seek to make submissions as to the conclusions which should be drawn from the evidence. That is entirely a matter for the Chairman. I do, however, propose to identify those issues which might be thought by the Chairman to be of particular importance. In so far as I may appear to suggest or imply any particular conclusion that is merely my view. The Chairman may well analyse matters quite differently.

The management and consequent changes in the administration of the Health Care Centre

13. The need for reform of the management of the Health Care Centre in the time prior to D's admission was obvious. The physical conditions had been condemned but plainly there was a limit as to what could be done to improve them within the existing accommodation. Nevertheless, it might be thought that the efforts to improve cleanliness were an obviously important step in the right direction. Similarly pressing was the need for improvements in the management of the existing facilities and staff: see the Chief Inspector's report of 1999 [5/2]. The Chief Inspector made specific recommendations which included improvement in clinical nursing leadership, the reduction in the size of the in-patient population and an improvement in the regime for in-patients. Governor Davies, Mr Monaghan and Mr Attard instigated measures with a view to meeting these recommendations. The size of the in-patient population was reduced, specially selected prison officers were transferred from the Wings and from April 2001 Kay George was appointed to the new post of Matron.

14. The Chief Inspector recognised that one of the areas which worked well at the Health Care Centre were the arrangements for visiting psychiatrists. This was a matter which it might be thought was in general terms reflected in the evidence, certainly under the "old" system for referrals.

15. It was clear on the evidence that Dr Yisa was not impressed by the changes that were instigated within the Health Care Centre by the new management.

16. It will be a matter for the Chairman to consider the extent to which, if at all, the systems in place for managing in-patients in the Health Care Centre operated effectively in relation to D, specifically in relation to (a) medical care, (b) nursing care and (c) specialist referrals.

Medical Care, Nursing Care and Specialist Referrals

17. Serious criticism is made of the clinical and nursing care provided to D. This is a central matter which the Chairman will wish to consider. One of the most striking aspects of this case, about which there was no dispute until the adjourned hearings, was the fact that despite D being referred to the visiting psychiatrists on at least 6 occasions he was not seen by a consultant psychiatrist. Ms Draper concluded that D was not seen by a psychiatrist. In the Prison Service's Opening Statement it was acknowledged that D should have been seen by a psychiatrist during December 2001 but was not (see paragraph 72). However, in evidence both Dr Yisa and Dr Ranaweera did not accept Ms Draper's conclusion. Neither was in a position positively to assert that D was seen by a psychiatrist but both thought it most unlikely he was not. In the light of their evidence the Prison Service has altered its position and now suggests (Closing, paragraph 29.3) that there is a "clear and compelling case … for concluding that D was in fact seen by a psychiatrist".

18. In my submission, in the circumstances of this case the burden is upon the Prison Service to establish on the balance of probabilities what treatment was provided by it to D. If, as the Prison Service now submits, D was seen by a consultant psychiatrist, the burden is upon the Prison Service to prove on the balance of probabilities that he was.

Consequence of being seen or not seen by a psychiatrist

19. This is a matter of dispute between the Interested Parties both of whom pray in aid the expert evidence adduced by each of them. There is, of course, a fundamental difficulty recognised by both experts that the diagnostic task they were invited to undertake was inevitably speculative. The value of their opinions on this issue must be limited by the absence of contemporaneous Prison Service medical records and the fact that neither examined D contemporaneously. Nevertheless, within their respective areas of expertise and on the basis of such information as was available to them, each has sought to assist the Investigation. The Chairman will wish to consider their evidence with care.

Dissemination of available information

20. There is an issue as to the extent to which information about D was effectively disseminated amongst those who needed to know it. Prof Rogers and Dr Cumming agreed that it was important that those responsible for the care of individuals such as D are in possession of as much information as is possible. In his short time at the prison D had a troubled history, but it appears from the evidence that this was not recorded in a consistent manner and in such a way that staff with responsibility for him had a complete picture of his behaviour. Thus, for example:

(a) Mr Leane and Nurse Chikuku were unaware that razors and a noose had been found in D's cell on the morning of 27 December. Mr Richards, who made the discovery did not record the location;

(b) There are no entries in the Wing Observation book relating to D between 15 and 27 December notwithstanding that on 16 December he had a period of head banging, on 19 December he was throwing things in his cell and on 25 December he said that he was going to die that night but subsequently told staff he was OK;

(c) There is no entry in the Wing Observation book relating to 4 December when D was found to be ripping dressings from his arms and saying that he did not want to live, or for 6 December when he was seen to rip up a sheet and attempt to conceal it;

(d) Some matters are recorded in the Wing Observation Book and some in the F2052SH and some in both;

(e) Mr Hayward, who returned to work on 27 December after a period of leave, recollects that he would have looked at the entries in the Observation Book and the F2052SH for the days over the Christmas period;

(f) The IMR was not (no doubt for good reason) available for inspection by wing staff.

21. It might be thought that it is important to have an effective system, whether by way of record keeping and/or handovers, that ensures so far as is reasonable that those responsible for the care of inmates such as D are in possession of all relevant information about his behaviour and conduct. It will be a matter for the Chairman to consider the extent to which that was so in this case and whether, if it was not, that contributed in any way to the events of 27 December.

<u>Time between D being retuned to his cell after the phone call and the discovery of him hanging</u>

22. There is an important issue on which in my submission a finding of fact should be made: namely, the time that elapsed between D being returned to his cell after the phone call and the discovery of him hanging. There is no dispute that, time permitting, some action was required in the light of D's distressed state. Thus, the lapse of time here is a central issue. The shorter the time, the shorter the window of opportunity for action to be taken.

23. On this issue the Chairman will wish to consider the totality of the evidence given by each witness and assess its reliability. The Interested Parties have summarised the evidence (PS, Opening para 43, Closing para 9; D, Closing para 22).

Should D have been returned to his cell and left alone after the phone call?

24. The evidence is that D was distressed following his phone call. Mr Leane was plainly concerned about him. Mr Hayward says that he intended to go and see him. There is no dispute that he was returned to his single cell where he remained on 15 minute observations. There is no positive evidence that Nurse Chikuku was told about the phone call: she says she was not whilst Mr Leane has no recollection of telling her but thinks he would have.

25. The Chairman will wish to consider whether returning D to a single cell and leaving him alone albeit subject to 15 minute observation was an appropriate course of action in the circumstances as they were known or as they ought to have been known, or whether more ought reasonably to have been done to care for D at that time.

Reaction of staff to discovery of D

26. There can be no doubt that staff on the Wing reacted promptly to the discovery of D hanging in his cell. The benefit of Mr Haywood's efforts to establish a team to respond to such an emergency was manifest. The Chairman will, however, wish

to consider the criticism made of the delay in the provision of anti-ligature scissors and the extent to which, if there was some delay, that could reasonably be avoided.

FUTURE INVESTIGATIONS

27. The Chairman has invited submissions as to any lessons that might be drawn from this investigation for the future. From my perspective, the following matters seem to me to be of significance:

(a) Documentation and Hearing Bundles

The papers were prepared for the hearing in accordance with my advice. The end result was that the hearing bundles ran to 10 lever arch files (excluding witness statements and experts' report). The extent to which these were referred to in the course of the public hearings was limited. Nevertheless, the bundles had to be copied and read. On reflection, it seems to me that, for the future, Counsel to the Investigation in consultation with the Interested Parties may think it appropriate to offer more robust advice with a view to restricting the documentation prepared for the public hearings to that which is absolutely necessary.

(b) Expert evidence

My view at the outset was that expert evidence was not reasonably required. In the event, expert evidence was adduced by both the Interested Parties. There can be no doubt that both Professor Rogers and Dr Cumming have provided the Investigation with valuable evidence, both written and oral. I agree with the suggestion made by the Prison Service that the need for expert evidence in any future inquiry should be considered on a case by case basis. There should be no presumption in

favour of expert evidence. However, where a need for such evidence is identified the Chairman should consider adopting the approach initially suggested by D's representatives of himself instructing a single expert.

(c) Questioning from Counsel to the Investigation

I sense that the procedure adopted for examining witnesses is generally thought to have worked well. By and large it served to ensure that the hearings did not become adversarial, as frequently occurs at inquests. However, the overriding consideration must be to ensure that the relevant facts are fully and fairly investigated. It seems to me, therefore, that questioning by Counsel to the Investigation should not be seen as a means of ensuring such proceedings will never become adversarial. There may be occasions when that it unavoidable.

(d) Purpose of Closing Submissions from Counsel to the Investigation

Consideration should be given as to the purpose, if any, of closing submissions from Counsel to the Investigation. I have taken the view that it is not my function to contend for or suggest any particular findings of fact or to perform an assessment of the evidence. However, if that is the correct view it necessarily means that these submissions are of limited value.

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