

REPORT ON

“D”

Instructed by:

Bindman & Partners
275 Gray's Inn Road
London WC1X 8QB

By

PROFESSOR PAUL ROGERS

PhD, MSc (Econ), RN, Cert ENB 650 Beh Psychotherapy, Dip Beh Psychotherapy
Professor of Forensic Nursing

Instructions

1. I have been instructed by Bindman & Partners to provide them on behalf of D and the Official Solicitor an expert opinion on relevant health issues and clinical care, as well as any policy issues arising from the treatment of D at HMP Pentonville during the period 30 November 2001 – 27 December 2001, the date of his attempted suicide. The report is requested in the context of a Public Inquiry into the circumstances of the attempted suicide of D at HMP Pentonville. I understand that the terms of reference of the Inquiry are as follows:

Having regard to the Court of Appeal Judgment of 28 February 2006 to conduct an Article 2 compliant investigation into and report to the Secretary of State for the Home Department on the circumstances surrounding the near suicide of a young man (D) at HM Pentonville on 27 December 2001. In particular:

- To establish the circumstances and events, especially as regards management of Mr D by the Prison Service, including considering any information about how prisoners at risk of self harm were cared for at Pentonville and to consider relevant outside factors.
- To examine whether any change in operational methods, policy, practice or management arrangements would help prevent suicide and self harm in Pentonville and other prisons.
- Where possible to examine relevant health issues and to assess Mr D's clinical care and consider any wider policy issues arising.

- To provide explanations and an insight for Mr D and his family.
 - To examine the extent to which the recommendations of the earlier internal Prison Service investigation had been implemented.
 - To consider the implications for future investigations into near suicides.
2. I understand that although the report has been commissioned by Bindman and Partners, the Chairman of the Inquiry has agreed that he will consider the report and that it will also be made available to the Prison Service.
 3. At the end of my report I will also deal with specific questions raised by Bindman and Partners. Specifically: Was there a risk to D's life on the facts of his case as known? What was the nature of that risk? Were the means being used to deal with the risks adequate and if not why not? What could and should have been done?

Background of Professor Rogers

4. Attached as Appendix 1.

Method of forming opinion

5. In order to form my opinion, I have considered that information which was provided to me (as specified in Appendix 2). I will provide an account of the events leading up to Mr D's suicide attempt and provide observations on the care and treatment provided to him by the staff at Pentonville Prison. I have placed direct quotes from the documents

in quotation marks and italics. I have only changed quotes in one respect; using the term Mr D.

6. My opinion is based solely on my review of the available notes; I have not interviewed any of the parties involved, neither have I visited any premises related to the case.

7. I must express my concern at the outset about the number of important documents which are missing. Specifically, the lack of Inmate Medical Record, as without these, I have found it very difficult to review the care that Mr D received. Additionally, I have reviewed the available policies, prison service orders, etc, which I can be sure were relevant prior to 27th December 2001.

8. It may assist the Inquiry if I set out the situation as I see it in relation to the standards of care that a prisoner should have expected at the time of MR D's attempted suicide. Prison health care was omitted from the NHS when this was set up in 1948. However, there have been a number of recent developments, which have led to the decision that the responsibility for prison health care has been transferred to the Department of Health in 2004. However, many years ago a report by the Home Office (1990) set out the principle of the prison service aiming to provide prisoners with a health care standard which was the same as in the NHS. This report was followed up by a strategy document, published by the HM Inspectorate of Prisons (1996) entitled "Patient or Prisoner? This was produced by Her Majesty's Chief Inspector of Prisons, in which the matter of equivalence was the central issue. This report concluded "it is no longer sensible to maintain a health care service for prisoners separate from the National Health Service," and that "the NHS should assume responsibility for the commissioning

and provision of health care and health promotion in prisons." The report emphasised the importance of treating those who are ill in prison as patients rather than prisoners.

9. In turn, the Health Advisory Committee for the Prison Service (1997) reinforced this position by stating, unequivocally, that prisoners should be entitled to expect the same standard of health care as that provided in the community, and have similar access to NHS beds. Therefore, at the time of the period in question, there was, in my opinion, a clear understanding within the prison service that all prisoners should expect the same standards of care as that provided within the NHS. Consequently, I will consider the standards of care both as relating to prison healthcare but also the wider NHS.

The Draper Report

10. Paragraph 3.3 of the report of Carol Draper (Bundle 4, section 1), reports that: "*Mr D, having spent the previous night in police custody, was received in court on 30.11.01 with a prison escort record where suicide or self harm was noted as a warning, as well as a box indicating existing injuries. A F2052SH was opened up in court by Securicor staff on 30.11.01. A special watch was brought in and they checked him every 15 minutes. After appearing in court that day he was noted to have further injuries and was transferred to Whitechapel Hospital where his injuries were treated. Following his discharge he was placed in the van under constant observation until his arrival at Pentonville*".
11. Paragraph 3.4 of the Carol Draper report (Bundle 4, section 1), reports that: "*Mr D was assessed in reception and was admitted to the Health Care Centre on an open F2052SH and was also given an alcohol detoxification prescription. He was found to*

have deliberately self-harmed on both arms and stated that he felt very depressed due to the breaking up of his relationship with his girlfriend who was pregnant by his friend and that he felt hopeless about the future. Mr D was admitted to the shared ward facility, Ward 3, and referred for an urgent assessment by medical staff. A doctor saw him at 17.30 hours and referred him to the visiting psychiatrist”.

12. Paragraph 3.6 of the Carol Draper (Bundle 4, section 1), report notes that: *“by the afternoon of 1 December he had become disturbed and was relocated to R1 after threatening staff. He remained disturbed and at 18.10 hours threatened to self harm with a pencil. Although tearful he remained quiet for the remainder of the night and appeared to sleep for most of the following day”.*

13. Paragraph 3.7 of the Carol Draper (Bundle 4, section 1), report notes that: *“during 3 December a full history was taken by a doctor and Mr D admitted that he had a history of self harm and had previously been in the Young Offender Institution but this was his first time in an adult prison. He admitted to a heavy alcohol habit”.* Additionally in paragraph 3.7 of the Carol Draper report, it is noted that: *“he had lived with his girlfriend for 2½ years and had a child by her. He was anxious and seemed to have multiple superficial lacerations to both arms, but was not considered actively suicidal nor clinically depressed. He was referred to the visiting clinical psychologist for counselling and a visiting psychiatrist for a mental assessment as well as the Chaplain, Samaritans and listeners.* I assume that this relates to the referral form (pages 122-125, Tab 12, Bundle 1) that Dr Ranaweera completed to Psychiatry / Psychology to the North London Forensic Service and that this is marked “urgent”. I note that the date on the form is either 3 or 5 December 2001. The reason for referral is recorded as “alcohol

abuse”, “p/h mental illness” (p/h meaning past history),? referred to St Clementine Hospital in the past”, “H/o self harm + on f2052SH”, “relationship problem -> for urgent assessment by clinical psychologist for counselling”. A box is ticked “one week” next to the question on the form asking degree of urgency.

14. Paragraph 3.8 of the Carol Draper report (Bundle 4, section 1), notes that: *“the same day Mr D self harmed at 09.40 hours by stabbing himself in the arm with a knife and threatening to kill himself. He later settled for a while and took part in association during the afternoon. At 19.40 hours he barricaded his cell and again self harmed by inflicting multiple lacerations to both arms with a piece of porcelain from his toilet. He was relocated to Ward 3 where he remained tearful and low in mood. He was seen by a doctor at 21.15 hours the same night, who prescribed some medication and referred him urgently to the visiting psychiatrist”*.
15. It is difficult to determine from the Draper report whether this is a separate referral than that already referred to in 3.7 or refers to the same referral. Paragraph 3.12 of the Carol Draper report (Bundle 4, section 1), noted that he wasn’t seen by a psychologist until 18th December for an assessment: *“on 18th December, he was seen by R Halsey, the visiting clinical psychologist. There is no record of Mr D ever having received an urgent psychiatric assessment. Page 345 of Bundle 2, reports on the Transcript with Dr Ranaweera that Dr Ranaweera “considered it unusual that Mr D had not been seen by the psychiatrist within 3½ weeks of referral”*.
16. Paragraph 3.9 of the Carol Draper report (Bundle 4, section 1), noted: *“at 09.40 hours on 4 December, was moved from Ward 3 to a S3 (a safe cell) after once again self*

harming. Mr D was described as hysterical, agitated and uncooperative, and he claimed that he could hear voices that were telling him that they were going for his daughter. He was given emergency sedation, (with consent) after being considered a risk to himself and others and was placed on a documented 15 watch. The Senior Medical Officer requested an urgent referral to psychologists and psychiatrists". I can only assume that as this paragraph most clearly relates to the 4th December that the mention that the Senior Medical Officer is requesting an urgent referral to psychologists and psychiatrists that this is separate to that reported on 3rd December where urgent referral to psychiatrists and psychologists was reported.

17. Paragraph 3.11 of the Carol Draper report (Bundle 4, section 1), notes that: *"at 12.00 hours Mr D ripped off the dressings from both of his arms and told staff that he did not want to live". Paragraph 3.11 also reports: "he was assessed by the doctor who kept him on a one to one watch and noted that he was awaiting the assessment by the specialists".*
18. Paragraph 3.12 of the Carol Draper report (Bundle 4, section 1), notes that on 6th December: *"he was seen to rip up a bed sheet which he attempted to conceal in his cell but was seen and he voluntarily gave up the sheet when asked to do so".*
19. Paragraph 3.13 of the Carol Draper report (Bundle 4, section 1), noted that: *"on 7th December he went to court where he was further remanded until 14 December. He was seen to be removing dressings from his arm and later was found to again of self harmed with pieces of broken tile from the cell sink. He told staff that they would not stop him self harming if he could not see his daughter. He was seen by the FME but was not*

given any further treatment, but returned to Pentonville for further assessment. He was considered to be very distressed and was treated for Lockjaw during the evening". I note that the report of Carol Draper does not give any reason why Mr D had lockjaw. However, it was probably a side effect from administered medication as reported on 04.12.01 (reported on page 66 of the extracts from information book – December 2001 (Section 5 Bundle 1)). I also note on page 67 of the extracts from information book – December 2001 (Section 4, Bundle 1) that it reports "IM medication given today. Doctor Yisa's Inst do not give any further meds today or tomorrow 4th and 5th December" (? entered by D Carr).

20. Paragraph 3.14 of Carol Draper's report (Bundle 4, section 1), noted that: *"he was seen by a doctor on 8th December and was kept on one to one watch"*.
21. Paragraph 3.15 of the Carol Draper report (Bundle 4, section 1), noted that: *"case conferences were held on 10 and 11 December during which it was felt that Mr D was far more settled, with no thoughts of self harm or suicidal ideation, although the F2052SH was kept open and his level of watch was reduced initially to a 15 minute documented watch, (on 10 December) and then to a 15 minutes supported watch (11 December)"*.
22. Paragraph 3.16 of the Carol Draper report (Bundle 4, section 1), noted that *"on 13th December there was a further case conference during which Mr D was discussed. He was considered to have settled well and not to be either clinically depressed or suicidal. The proposal was to relocate him to normal location in a shared cell, maintaining the F2052SH and for him to be assessed by the visiting psychologist and psychiatrist in the*

outpatients department when arranged. A support plan and discharge report was drawn up in the F2052SH”.

23. Paragraph 3.17 of the Carol Draper report (Bundle 4, section 1), then noted: *“however, at 14.00 hours Mr D attempted to self harm by tying his bedding around his neck and was subsequently seen by the doctor who authorised a documented 15 minutes watch, referrals to Listeners, Samaritans and Probation, and placed him in a semi-furnished cell with special clothing and bedding and the removal of all items with which he could self harm. Mr D appeared to settle for the remainder of the day.”*

24. Paragraph 3.17 of the Carol Draper report (Bundle 4, section 1), seemed to under-report the severity of the incident occurring around 2.00pm. Page 70 of the extracts from information book – December 2001 (Section 5, Bundle 1) reported: *“at approximately 13.55 this man was found hanging by PSN Abani, alarm raised and D was saved”*. Next to this entry it is reported that he was: *“seen by Dr Yisa and placed on one to one”*. It is also important to note that on page 69 of the extracts from information book – December 2001 (Section 5, Bundle 1) that prior to his “hanging” it is reported: *“brought in from exercise wanting to see MO, asking me to give him something to help him sleep through the day, when advised as to my position, demanded to see a doctor, inmate informed all doctors unavailable due to clinical meeting, started throwing his furniture around the cell and sighting verbal abuse of a highly charged and sexual nature”*. Next to this entry under the column Action Taken, the staff have entered *“what action is being taken?”*.

25. To put this into context, unless the Case Conferences occurred all day, it appears that whilst the staff were having their case conference as reported in Carol Draper's report (paragraph, 3.16) where they considered him to *"have settled well and not to be either clinically depressed or suicidal"*, he was asking to see a doctor in order to have medication and he was refused because they were in a meeting. As such, it would appear that while the case conference was considering him to *"have settled well"* he was *"throwing his furniture around the cell and sighting verbal abuse of a highly charged and sexual nature"*.
26. Paragraph 3.18 of the Carol Draper report (Bundle 4, section 1), noted that: *"Mr D attended court on 14th December under constant watch by Securicor staff. He returned to Pentonville and was returned to cell AS3, described as a semi-furnished cell and placed on a documented 15 minutes watch until he was seen by the doctor"*.
27. Paragraph 3.19 of the Carol Draper report (Bundle 4, section 1), noted that: *"the following day he was moved from AS3 to R1-21, a single cell. He remained settled, interacting with staff and other prisoners. At 1500 hours on 16th December he had a period of head banging, telling staff that he was missing his daughter, however after talking with staff this stopped and he went on association"*.
28. Paragraph 3.12 of the Carol Draper report (Bundle 4, section 1), noted: *"on 18th December, he was seen by R Halsey, the visiting clinical psychologist who described him as presenting as tearful, depressed and miserable. Mr D claimed that he could hear his girlfriend's voice telling him to kill himself. Mr Halsey said that he would see him again in the New Year but in the meantime, Mr D required a thorough psychiatric*

evaluation. He was listed for the visiting psychiatrist the following day but notes that if he was not seen for any reason then Mr D should be included on the list of one of the visiting psychiatrists at the earliest opportunity”.

29. Paragraph 3.22 of the Carol Draper report (Bundle 4, section 1), noted that: *“on 19th December he became angry at about 12.00 hours and started throwing things around in his cell but was unwilling to tell staff why. He was apprehensive during the night about his forthcoming court appearance on 20th December but in the event this went without incident and he returned to Pentonville during the evening of December 20”.*

30. Paragraph 3.23 of the Carol Draper report (Bundle 4, section 1), noted that: *“Mr D participated fully in the healthcare regime over the next few days, interacting well with staff and other prisoners and entries into the F2052SH suggested that he was in quite a congenial mood”.*

31. Paragraph 3.24 of the Carol Draper report (Bundle 4, section 1), noted: *“Christmas eve and day passed without significant incident although there was an entry at 1645 on Christmas Day to say that he had called out to another prisoner and stated that he was going to die that night. He told staff that he was not alright but would not elaborate on this. However no further incidents occurred and he settled for the night. Boxing day passed uneventfully.”* I am surprised that Carol Draper wrote that the day passed without significant incident on Christmas day when it is reported that *“he had called out to another prisoner and stated that he was going to die that night”.*

32. Paragraph 4.1 of the Carol Draper report (Bundle 4, section 1), noted that: *“during the conducting of cell fabric checks during the morning of 27 December, Mr D was discovered with a broken razor in his cell and a noose. He told staff that the former was for cutting matches and the latter was only intended to be a joke. The member of staff who discovered them reported the finds to senior staff on duty and continued with his duties”*. Interestingly page 71 of the extracts from information book – December 2001 noted that: *“medication found in cells, razors and a noose”*. Signed by Richards. As the entry is plural, I assume that this is a description of a search of more than one cell and therefore I would assume that the references to finding razors and a noose correspond to the razor and a noose in the Draper report. Unfortunately, it is not possible to determine where the medication was found.
33. Paragraph 4.2 of the Carol Draper report (Bundle 4, section 1), noted that: *“there are few entries in the F2052SH to cover the morning, but it would appear that Mr D remained quiet for the period. He appeared to sleep during the lunch time period but at 1500 hours he smashed his locker stating that he could not stand being “banged up” any longer. Staff removed the furniture from his cell as a precaution”*.
34. Paragraph 4.3 of the Carol Draper report (Bundle 4, section 1), noted that: *“Officer Leane, a Discipline Officer working in Healthcare agreed with HSCO Hayward, who was in charge on inpatients for the day, that Mr D could be given a telephone call at official expense, in the hope that it would settle and reassure him.”* It is important to note that it is the Discipline Officers working in the inpatient ward that are making the decisions as to how to settle and reassure Mr D at this time.

35. Paragraph 4.4 of the Carol Draper report (Bundle 4, section 1), noted that: *“during the telephone call, Mr D learnt that his daughter had been taken into social services care, which caused him great distress. He was very tearful and obviously distressed after the call, although he was placed in his cell. An entry was made in the F2052SH and healthcare observation book that staff should be extra vigilant in relation to Mr D.*
36. Paragraph 4.5 of the Carol Draper report (Bundle 4, section 1), noted that: *“At 1550 hours Mr D was discovered hanging by agency nurse Chikuku who was responsible for the documented 15 minute watches on prisoners for the day. She had last seen him about 10 minutes before. The alarm was raised and the health care response team arrived and took over the incident.”*
37. Paragraph 4.6 of the Carol Draper report (Bundle 4, section 1), noted that: *“Mr D was cut down and resuscitation started. An ambulance was called and, very quickly both a land ambulance and the air ambulance arrived.”*
38. Paragraph 4.7 of the Carol Draper report (Bundle 4, section 1), noted that: *“Mr D was fitted with an airway and was given adrenaline by the prison doctor, Dr Khan. He was also fitted with a spinal collar in case of spinal injury. The HEMS doctor arrived and after assessing Mr D intubated him and had him relocated onto a spinal board. Mr D was then transferred to the Royal Free Hospital, escorted by 2 staff. He remained in the Royal Free for several months.”*

Carol Draper's Interview with Nurse Chikuku (Section 3, Bundle 4)

39. Page 2 of the interview with Nurse Chikuku (Section 3, Bundle 4), reported that Nurse Chikuku stated: *"when he came back, I went in. He didn't want to speak to nobody but I didn't find any distress in him or in a low mood or whatever, he was just the same as he was in the morning. Then I checked the others. I spoke to one of his neighbours, he didn't say much he just told me that he phoned his girlfriend but he didn't want to talk about it."* Carol Draper then asked: *"did the staff tell you anything about the telephone call?"* Nurse Chikuku replied: *"No"*. Carol Draper asked: *"No, they didn't, sorry carry on"*. To which Nurse Chikuku replied: *"Then when I came back again after 10 minutes there was a newspaper on the flap and I just take the newspaper off then I saw Mr D hanging himself. I call for help, I call for scissors and placed the alarm – that's when the crew came in."* This is slightly confusing when considering what Nurse Chikuku said on the bottom of page 4 leading onto the top of page 5. Nurse Chikuku reported *"that same shift, I asked if I could go to the ward and the following day I was coming in again. They wanted me to do the 2052's. I said "I am uncomfortable to do that at the moment", so I was sent to the ward. The reason why is because whenever I pass by his cell I could see the whole thing coming back again to me and asking his neighbour after that he told me that he had told him that he was going to do something stupid because of the phone call and he asked him what type of phone call it was and he told him that his daughter was taken away from girlfriend so that was why he was really down about it. He felt like there wasn't much he could do to help save the baby."*
40. Unfortunately I cannot understand what this means. I am not sure if Nurse Chikuku is adding extra information to what she earlier said or was stating that she had received further information from the neighbour **after** the event which was new information to

her. At the bottom of page 3 it is reported that Carol Draper asked: *“and he hadn’t said anything to you about being particularly upset or anything else?”* To which Nurse Chikuku replied: *“no he didn’t”*. Carol Draper then asked *“did none of the staff, because he had had the telephone call and did any of the staff not say anything to you about whether or not to keep a particular eye on him or be careful because he had just had a bad telephone call?”* Nurse Chikuku replied: *“No”*. Carol Draper then asked: *“nothing at all like that”* to which Nurse Chikuku replied: *“Nothing”*.

Carol Draper’s Interview with Officer Leane (Section, 4, Bundle,4)

41. Page 3 and 4 of the interview by Carol Draper of Officer Leane (Section 4, Bundle 4), notes that in relation to the phone call from Mr D that Officer Leane: *“got him out and said, “Where is your phone card?” and he didn’t have a phone card so then I asked Mr Hayward. I said, “Is it alright for a public expense phone call” and Mr Hayward said yes. He was SO at the time. He said yes. So I took him to the office and remember because it was a mobile phone number and I know what the Governors here are like for mobile phones and all of the rest of it so I gave him a 2 minute call. Now during the call, he was talking to his girlfriend. I can’t remember her name. Anyway he was talking for maybe about 5 minutes and his words to me when he put the phone down he said, “I have lost my daughter”. At that minute I thought “Oh my God his daughter’s died, or his son”. I think it was a daughter, I am not sure. Anyway his child and I thought the child had died and he was in pretty much of a bad way. Then he informed me that Social Services had taken the child so then I took him out, obviously put him back in his cell, informed Mr Hayward. I think he put something in the observation book and he was already on a 15 minute watch and they were quite happy with that but he was pretty much in a bad way”*.

42. On page 4 (Section 3, Bundle 4), Officer Leane responded to Carol Drapers question *“and there was also an entry made in the 2052”* with the following: *“Yes, because obviously I was concerned about him and as it turns out rightly so.”* I am slightly confused by Officer Leane’s statement. On page 4 (Section 3, Bundle 4), he states that the following occurred after the phone call *“then as I said I approached Mr Hayward, told him we would keep an eye on him, put it in the observation book”*. But then on page 7 (Section 3, Bundle 4), Officer Leane was asked by Carol Draper: *“and was there any discussion when he had had that telephone call as to whether or not the obs ought to be increased or was it just a more frequent informal watch at that stage?”* Officer Leane replied: *“Yes, I think it was more informal at the minute because he was on 15 minute watch and obviously to put them on a 24hour they have got to be seen by a doctor”*. Therefore, initially, Officer Leane stated that he approached Mr Hayward and told him he would keep an eye on him and put it in the observation book. But later on in the interview states that he and Officer Hayward had a discussion about whether the 15 minute observation was sufficient.

Carol Draper’s Interview with Senior Officer Hayward (Section, 5, Bundle, 4)

43. On page 6 (Section 5, Bundle 4), SO Hayward stated: *“I remember Officer Leane coming to me asking if D could have a phone call. I asked him why and he explained to me that he was having problems. I think his children, from what I could recall, were going to be taken into care or something like that. He was anxious to talk to either his girlfriend or somebody to find out about it.”* Carol Draper replied: *“What was happening with the children”*. SO Hayward replied: *“so I said to Dave, “Yes go and let him out and let him use the phone”*. *On coming back from the phone, Officer Leane lent in and said “look you want to watch him because I think he is a bit upset, his*

children are going into care apparently”. Carol Draper replied: “Yes, he had just been told that over the phone”. To which SO Hayward replied: “and he could be a cause for concern. I said, “Right ok”. So that is when I annotated the 2052SH and made the comments.” Carol Draper replied: “he was already at that stage on a documented 15 minute watch, I understand. Did you give any consideration to actually increasing that or have you got the opportunity to increase that in terms of as a Health Care Senior Officer without a doctor?” SO Hayward replied: “well, it is debatable because at the time there was an Agency Nurse there doing 15 minute watches. To be honest with you and wrong though it may seem, is that we have a lot of people threaten self harm. If I put an agency nurse on constant observations on every inmate because he is a bit vulnerable then we would have a whole landing of agency nurses. Knowing D from what I did, he was always a little bit demanding as such and keeping himself in the limelight to a certain degree so therefore I thought no, the agency nurse is there, they are going to keep an eye and I will discuss it with a doctor, get the doctor to go and see him. Literally from what I can remember, it seems like just after I put the entry in, but obviously with the timings, there was a little bit of time in between, then I heard the agency nurse shout and the whistle go. I don’t know, I believe it was David Leane who blew the whistle, I am not sure. I am not sure. Then went down to the cell and saw that D had suspended himself from his light fitting.”

44. On page 11 (Section 3, Bundle 4), Carol Draper stated: *“you made the point of making the entry in the 2052 to keep an extra eye on him.”* SO Hayward stated: *“I think I wrote it in the Obs book as well actually”*. Carol Draper stated: *“you did, yes. It is also in the Obs book. How would that actually have been passed by word of mouth to staff that were on the landing at that stage?”* SO Hayward stated: *“well obviously from*

putting it in there and putting it in the observation book I then would have called it to the staff's attention. Like I say, I can't remember how many people were there on the landing because we are very short at the moment. I remember telling somebody, but I can't think of her name to be honest with you, I can't think of her name and by that time had come and gone and then it all sort of kicked off. Obviously when the staff had turned up, if we were going to associate them then when I had the crooks of them there, the majority, then I would have given a briefing." Carol Draper then stated "you would have done it on a sort of normal evening briefing or the daytime briefing for the following day." SO Hayward stated "Dave was certainly aware and I asked him to pass it onto the nurse who was looking just to make them a bit more vigilant and like I say from there on it just went a bit pear shaped." On page 6 SO Hayward stated: "at the time there was an agency nurse there doing 15 minute watches. To be honest with you and wrong though it may seem, is that we have a lot of people threaten self harm. If I put an agency nurse on constant observation on every inmate because he is a bit vulnerable then we would have a whole landing of agency nurses."

45. It is very difficult to determine the exact nature of the events around the critical time after the decision to give Mr D a phone call and the communication to staff of his distressed state due to the inconsistencies of staff reporting of the event at the time.

Transcript with Dr Ranaweera

46. On page 348 of Bundle 2, Ali McMurray asked: "do you remember Mr D at all?" Dr Ranaweera replies "No, unfortunately the medical records or IMR (Inmate Medical Record) is not available. The interview then focuses on what may have happened. Page 345 of Bundle 2, reports on the Transcript with Dr Ranaweera that Dr Ranaweera

“considered it unusual that Mr D had not been seen by the psychiatrist within 3½ weeks of referral”.

Referral form from Dr Ranaweera to Psychiatry / Psychology (North London Forensic Service)

47. I note that Dr Ranaweera completed a form for Psychiatry / Psychology to North London Forensic a Service and that this is marked “urgent” (pages 122, Tab 12, Bundle 1). I note that the date on the form is either 3 or 5 December 2001. The reason for referral is recorded as “alcohol abuse”, “p/h mental illness” (p/h meaning past history), “referred to St Clementine Hospital in the past”, “H/o self harm + on f2052SH”, “relationship problem -> for urgent assessment by clinical psychologist for counselling”. A box is ticked “one week” next to the question on the form asking degree of urgency.

Summary of a Meeting with Robert Halsey (Section 9, Bundle 4)

48. Page 2 (Section 9, Bundle 4), of the summary of the meeting it is stated that *“although in the case of D there had not been any recent misuse of drugs, there had been problems with alcohol, and he had been assessed as in urgent need of a psychological and underlying psychiatric referral. Robert Halsey recommended that he saw a psychiatrist as early as possible, a fact he noted in the IMR. He would normally at that stage either do a verbal summary to a senior member of the nursing staff or on occasions to the referring medical officer him/herself. He could not remember in relation to D although he did confirm that he had followed up the referral in writing although, as already stated, this did not occur until 25th January 2002”.*

Letter from Dr Robert Halsey to Dr Ranaweera dated 25 January 2002

49. Dr Robert Halsey wrote to Dr Ranaweera dated 25 January 2002 (pages 125, Tab 12, Bundle 1). Dr Halsey provides an account of his assessment of Mr D: *“he was largely preoccupied with providing me with details of the break up of his relationship with his girlfriend and relaying the stress it caused him. He repeatedly returned to the theme of wanting to die and his attentions to kill himself. He also reported suffering from auditory hallucinations in which he hears the voice of his ex-girlfriend telling him to kill himself which he told me he acted on in the past, for example by throwing himself under a bus, and also jumping in to the river Thames from Woolwich Pier. He told me that whilst an inpatient at the Royal London Hospital approximately 3 months ago, he cut his wrists. Mr D told me that he also suffers from nightmares in which he hears people shouting at him. He said that for this reason he is frightened to go to sleep”*.

Carol Draper’s Interview with Dr Yisa (Section, 8, Bundle,4)

50. Page 2 of the interview by Carol Draper of Dr Yisa reports the following: *“yes I remember Mr D because I believe I reviewed him for the first time when actually I assessed him myself on 4th December 2001. This is because he had become very, very agitated. He was very hysterical and he had smashed up 2 cells, broken a toilet and the window and cut his arm.”* To which Carol Draper replied: *“that’s right he deliberately self harmed didn’t he?”* To which Dr Yisa replied: *“Yes and he threw a chair at myself and at other people and he was deliberately banging his head against the wall and the sink unit. When I saw him I remember him telling me, “Doctor, these voices in my head please help me, stop them, please give me something to stop it”.* So he was asking for something to stop the medication, but at the same time he wasn’t really aware of what he was doing to himself or other people, he was just really acutely distraught. I

explained to him that I was giving him medication which is quite powerful and will help to settle him and tranquilise him and he agreed to this but he is finding it very difficult to.” To which Carol Draper replied: “Did he comply to take that medication, he agreed himself?” To which Dr Yisa replied: “Yes, he agreed himself”. To which Carol Draper replied: “So it was emergency sedation but it was with compliance with Mr D?” To which Dr Yisa replied: “He agreed to take it and I believe as a result of his state we left him on a one to one observation. He asked for fluids and other things to be included and for mental observations to be taking place. I believe I was involved in the case conference.”

51. I note that on Page 3 (Section 8, Bundle 4), of the transcript with Dr Yisa that he reported that: *“I did the case conference on the 6th and I think he had become more settled, no self harming anything like that. I also saw him again on the 6th..... yes I think this was just like a follow up really because I said his level of consciousness was full. Yes I saw him because I was concerned he had been banging his head too much and I just wanted to make sure that.”* From reading the transcript, Dr Yisa explains that he was *“happy that, although he had been banging his head, there was no physical damage as such so yes that is why he went to court the next day”*. Dr Yisa then stated: *“I think my next involvement was another case conference on 10th. “ Any proper write up is supposed to be in his 2052”*. Dr Yisa stated: *“He was not suicidal, no self harm intentions and at this time he was well enough for us to reduce his level of watch from a continuous one to a documented 15 minute watch and I believe he was recommended for Chlorpromazine, 50msg at night because he said he wasn’t sleeping very well, just to help him sleep. As far as I know anywhere there is a case conference I would have participated in it.”*

52. On page 4 (Section 8, Bundle 4), Dr Yisa stated: *“Yes there were incidents, intermittent incidents in between of self harm but it was all the time although he complained of voices in his head it was all the time he was upset about the separation from his family and the fact that he may lose his kid. So it was an emotional, psychological problem rather than a psychiatric illness, so it is not like he is (?)Schizophrenic or (?) Psychotic, he was somebody who was having an acute reaction to ... an emotional reaction to an ongoing thing. He was somebody who needed psychology and counselling rather than the psychiatrists and section although I think my advice was a referral to both of them, stressing one, psychology”*. It is important to state that Dr Yisa is not a psychiatrist and based upon the documentation that I have reviewed his qualifications are not entirely clear. However, I have some doubt as to whether he is suitably qualified to make these decisions without specialist advice – that of a doctor trained in psychiatry.
53. On page 5 (Section 8, Bundle 4), Dr Yisa stated: *“Yes it was because he was just really upset about what was happening outside and he was reacting to it and particularly he was desperate not to lose his family or his children.”*

Observation 1 – Self harm as a warning sign for attempted suicide

54. There were a number of warning signs that staff should be aware of which were relevant at the time of Mr D’s suicide attempt. Page 24 (paragraph 3.8) of Her Majesty’s Inspectorate of Prisons for England and Wales entitled – Suicide is Everyone’s Concern clearly reports: *“It is known that most prisoners who injure themselves, many repeatedly, do not go on to kill themselves. However, a significant proportion of those who commit suicide do have a history of self mutilation. It is known that in the community those who harm themselves are 100 times more likely to kill*

themselves than the general population and that 10 per cent of this group do eventually carry this out. Thus although self mutilation may become established as a coping device or a way of dealing with pain and staying alive, it may develop into a method of achieving complete release in death". Paragraph 3.9 reports: *"it is also important that it (self injuring behaviour) is responded to because of the possibility that it may develop into fatal self injury in the future"*. Consequently, it was well known within the prison service that previous self harming behaviour was a significant risk factor for a later suicide attempt.

55. Given that the relationship between previous self harm and future suicide attempts was known at that time, I am surprised that the risk of Mr D attempting suicide was not considered more seriously. In my review of the documentation, I have noted that despite the lack of the Inmate Medical Records, that there are numerous occasions where Mr D has either self-harmed, attempted suicide or expressed a wish to die. I have identified that this has clearly occurred on at least 16 separate occasions between 29.12.01 and 27.12.01, a period of 30 days. However, it is difficult to truly establish the exact number. Additionally, there are reports which are suggestive of behaviour in preparation of a suicide attempt that I have not included as one of the 16 occasions. For example, paragraph 3.12 of the Draper Report noted that on 6.12.01 *"He was seen to rip up a bed sheet which he attempted to conceal in his cell"*; and paragraph 4.1 of the Carol Draper report (Bundle 4, section 1), *"during the conducting of cell fabric checks during the morning of 27 December, Mr D was discovered with a broken razor in his cell and a noose*. The incidents that I can establish are as follows:

- 1) 29.11.01. *“He had spent the previous night in police custody and was received at court with PER marked with a suicide or self harm warning as well as the box indicating existing injuries”.*
- 2) 29.11.01. *“at 12.45 hrs, after he appeared in court, he was found to have further injuries” and an ambulance was called. He was taken to Whitechapel Hospital”.*
- 3) 01.12.01. *“He remained disturbed and at 18.10 hours threatened to self harm with a pencil. Although tearful he remained quiet for the remainder of the night”.*
- 4) 3.12.01 *““the same day Mr D self harmed at 09.40 hours by stabbing himself in the arm with a knife and threatening to kill himself. He later settled for a while and took part in association during the afternoon.*
- 5) 3.12.01 *“At 19.40 hours he barricaded his cell and again self harmed by inflicting multiple lacerations to both arms with a piece of porcelain from his toilet”*
- 6) 3.12.01 *“Says he will kill himself by Friday next before he has his court appearance”.*
- 7) 4.12.01 *“at 09.40 hours on 4 December, was moved from Ward 3 to a S3 (a safe cell) after once again self harming. Mr D was described as hysterical, agitated and uncooperative, and he claimed that he could hear voices that were telling him that they were going for his daughter. He was given emergency sedation, (with consent) after being considered a risk to himself and others”,*

- 8) 4.12.01 *“at 12.00 hours Mr D ripped off the dressings from both of his arms and told staff that he did not want to live”.*
- 9) 6.12.01 *“he was seen to rip up a bed sheet which he attempted to conceal in his cell but was seen and he voluntarily gave up the sheet when asked to do so”.*
- 10) 7.12.01 *“He was seen to be removing dressings from his arm and later was found to again of self harmed with pieces of broken tile from the cell sink. He told staff that they would not stop him self harming if he could not see his daughter”.*
- 11) 13.12.01 *“at 14.00 hours Mr D attempted to self harm by tying his bedding around his neck and was subsequently seen by the doctor who authorised a documented 15 minutes watch, referrals to Listeners, Samaritans and Probation, and placed him in a semi-furnished cell with special clothing and bedding and the removal of all items with which he could self harm” and “at approximately 13.55 this man was found hanging by PSN Abani, alarm raised and D was saved”.* I have considered that these are relating to the same event as the reports are only 5 minutes apart, however, it could be that they are separate.
- 12) 16.12.01. *“At 15:00 hours on 16th December he had a period of head banging, telling staff that he was missing his daughter”.*
- 13) 18.12.01 *“Mr D claimed that he could hear his girlfriend’s voice telling him to kill himself. Mr Halsey said that he would see him again in the New Year but in the*

meantime, Mr D required a thorough psychiatric evaluation. He was listed for the visiting psychiatrist the following day but notes that if he was not seen for any reason then Mr D should be included on the list of one of the visiting psychiatrists at the earliest opportunity”.

14) 25.12.01 *“there was an entry at 1645 on Christmas Day to say that he had called out to another prisoner and stated that he was going to die that night”.*

15) 27.12.01 *““during the conducting of cell fabric checks during the morning of 27 December, Mr D was discovered with a broken razor in his cell and a noose”*

16) 27.12.01 *“but at 1500 hours he smashed his locker stating that he could not stand being “banged up” any longer”.*

Observation 2 – Command hallucinations as a warning sign for attempted suicide

56. It may assist the Inquiry if I offer information about command hallucinations (auditory hallucinations or voices that tell people to do things) as known up to 27th December 2001. I reviewed this area very carefully for my PhD which was submitted to the Institute of Psychiatry and passed in 2004 (Please refer to Appendix 3).

57. In 2001, the evidence for command hallucinations and the risk of harm to others or self had not been found in a number of very poorly designed studies. However, despite this, there were a number of single case reports which clearly made a link between command hallucinations and violence to self or others. Quite simply, clinicians at the time were uncertain as to the relationship. As I was conducting my PhD into command

hallucinations, I regularly, at that time, discussed my PhD and the possibility of a relationship between command hallucinations and harm to self or others with many clinicians and although there was a lack of evidence to the relationship, the general consensus was that clinicians took the presence of command hallucinations as worrying when having to consider the risk an individual patient posed. For example, one Senior Consultant Psychiatrist informed me that even though the evidence was not clear, he would have great difficulty if a patient in the community told him he was hearing voices telling him to kill the patient's own mother and he then allowed the patient to continue living with his mother while hearing such voices.

58. In 2002, after the attempted suicide by Mr D., I published the first paper which found a relationship between command hallucinations telling a person to self harm and actual self harm attempts. Consequently, the evidence is such that command hallucinations telling a person to self harm are something which are a risk factor for self harming behaviour.

Observation 3 – The clinical impression taken by staff regarding Mr D

59. I am surprised at the clinical interpretation that Medical staff within the prison took in relation to Mr D's clinical presentation. The fact that Mr D had command hallucinations clearly indicated the possibility of a mental disorder. However, this seems to have been given very little weight. I do not know why the Medical Staff did not consider the probability that Mr D was suffering from a mental disorder at the time. Command hallucinations are a well recognised symptom indicating a mental disorder is present. There are occasions where a mental disorder may not be present when they are considered a "pseudo" and not a "true" hallucination. The distinction is made by a very

simple question - whether the person hears the voices inside their head (a true hallucination) or outside their head (a pseudo hallucination)? However, there is no evidence that this question has been asked. In the absence of this knowledge, I would expect any reasonable body of clinicians to err on the side of caution and assume that they were true.

60. Research that I conducted as part of my PhD may assist the Inquiry. I conducted secondary analyses of the MacArthur Violent Risk Assessment Data from America. The MacArthur Violence Risk Assessment Study is a well-known longitudinal study within the field of psychiatry and has been widely analysed and reported (Monahan et al, 2001). The MacArthur Violence Risk Assessment Study was designed with three principles: (i) to improve the validity of clinical risk assessment, (ii) to enhance the effectiveness of clinical risk management and (iii) to provide information on mental disorder and violence which will be useful in reforming mental health law and policy. The Executive Summary of the MacArthur Violence Risk Assessment Study (2001).

61. As I was using data that I did not collect, I was unable to determine whether the command hallucinations in the database were true hallucinations or pseudo hallucinations as this was never determined in the original study. The results found that of the 105 participants with command hallucinations, 93 (89%) had a primary diagnosis of either a psychotic disorder or a mood disorder, nine (8%) had a primary diagnosis of either a drug or alcohol abuse (8%) and three (3%) had a personality disorder. I hope this demonstrates the relationship between having command hallucinations and having a diagnosable mental disorder. However, it is important to note that this was a sample taken from a psychiatric hospital and not a prison setting. No evidence exists on this

issue from a prison population.. In my opinion, any reasonable body of doctors, even those who are not psychiatrists, would associate the presence of command hallucinations with a mental disorder where a person is reporting hearing voices telling them to hurt themselves. Additionally, in my opinion, I would consider that any reasonable body of doctors, even those who are not psychiatrists, would consider that the presence of command hallucinations in addition with the number and nature of previous self harm and suicidal acts and threats made by Mr D, to be alert to the real potential of future suicide attempts. I therefore cannot understand why Dr Ranaweera placed more emphasis on “relationship problem -> for urgent assessment by clinical psychologist for counselling” when completing a form for Psychiatry / Psychology to North London Forensic a Service and that this is marked “urgent” (pages 122, Tab 12, Bundle 1). I would have considered the need for a Psychiatric assessment and advice to be much more important than an assessment by a psychologist for relationship problems.

62. Furthermore, On page 4 (Section 8, Bundle 4), Dr Yisa stated: *“Yes there were incidents, intermittent incidents in between of self harm but it was all the time although he complained of voices in his head it was all the time he was upset about the separation from his family and the fact that he may lose his kid. So it was an emotional, psychological problem rather than a psychiatric illness, so it is not like he is (?)Schizophrenic or (?) Psychotic, he was somebody who was having an acute reaction to ... an emotional reaction to an ongoing thing. He was somebody who needed psychology and counselling rather than the psychiatrists and section although I think my advice was a referral to both of them, stressing one, psychology”.*

63. I do not agree with this interpretation. Mr D is clearly reporting a psychiatric symptom (command hallucinations) which is considered a psychotic symptom by any reasonable body of doctors. I can not understand why Dr Yisa states that it “*is not like he is (?)Schizophrenic or (?) Psychotic*” at the same time reporting that he was suffering from a recognised psychotic symptom. Dr Yisa described that on the 4th December 2001, Mr D as being “*very, very agitated. He was very hysterical and he had smashed up 2 cells, broken a toilet and the window and cut his arm.*” And “*Doctor, these voices in my head please help me, stop them, please give me something to stop it*”. So he was asking for something to stop the medication, but at the same time he wasn’t really aware of what he was doing to himself or other people, he was just really acutely distraught. Furthermore, that Dr Yisa “*explained to him that I was going him medication which is quite powerful and will help to settle him and tranquilise him and he agreed to this but he is finding it very difficult to.*”. I can only assume that Dr Yisa is referring to giving Mr D an injection of an anti-psychotic drug. Finally, I note that Mr D was prescribed Chlorpromazine 50mgs at night. Chlorpromazine is a medication which is given to people who suffer from psychotic symptoms and for those who suffer from schizophrenia. It is classified as an “anti psychotic” drug. Dr Yisa reports: “*I believe he was recommended for Chlorpromazine, 50mg at night because he said he wasn’t sleeping very well, just to help him sleep*”. However, Chlorpromazine is not indicated for sleep problems, in fact, one of the side effects is insomnia and another side effect is depression. I am unsure why Dr Yisa chose to give Mr D an anti-psychotic medication and not a recognised sleeping tablet for his sleeping problem if he believed that the problems were not related to a psychiatric illness.

64. In my opinion, it is clear that the medical staff did not recognise the probability of a mental disorder and instead, in my opinion, wrongly, focussed on his relationship problems. I believe that this view probably may have led them to consider it more important that Mr D see a psychologist rather than a psychiatrist (although it is reported that both were urgently requested). However, according to Dr Halsey, he wrote in the IMR that a psychiatric assessment was needed as soon as possible (page 2, section 9, Bundle 4), on the 18th December 2001. Therefore, I can not understand why the Medical Staff did not review their interpretation of Mr D's problems on the 18th December 2001 and ensure that the urgent Psychiatric assessment took place as soon as possible. This would have been 9 days prior to the attempted suicide.
65. Given the above, I am at a loss to understand why Mr D was not urgently assessed by a psychiatrist the whole time he was in Pentonville. In my experience, it is much harder to obtain a psychology assessment than it is to obtain a psychiatric assessment. Additionally, I consider it poor practice that no-one can offer a clear explanation as to why Mr D was not assessed by a Psychiatrist in the 24 days from when one was urgently requested until the time of his attempted suicide. I am confident that any reasonable body of doctors working in a prison setting would be very concerned if all requested urgent psychiatric assessments of prisoners took longer than 24 days. I am therefore surprised that the lack of assessment was not more assertively followed up after at least 2 weeks in response to a request for an urgent assessment. This view is endorsed by Dr Ranaweera on page 345 of Bundle 2, when Dr Ranaweera reports that he "*considered it unusual that Mr D had not been seen by the psychiatrist within 3½ weeks of referral*".

Observation 4 – The clinical management of Mr D from his admission into the Health Care Unit until his attempted suicide

66. It is my opinion that the management of Mr D was inadequate during his admission and prior to his suicide attempt. Unfortunately, there is a lack of information about when the Care planning meetings took place, what was discussed, who was present, what action was recorded, whether they were multi disciplinary, whether D was present and if not, why not. Indeed, we have some evidence that Mr D was not allowed to see a doctor when he requested one because they were having a meeting (paragraph 3.17 of the Carol Draper report, Bundle 4, section 1). As far as I can determine, the Draper report makes reference to care meetings taking place on 4.12.01, 6.12.01, 10.12.01 and 13.12.01. Again as far as I can determine, there is no mention of Care planning meetings taking place after 13.12.01, even though, Mr D was had attempted to hang himself on 13.12.01 at 14.00hrs. It is possible that they discussed Mr D after this attempt in their meeting on the 13.12.01, but I cannot be sure as the times of the meetings are unknown. However, even if they had of discussed Mr D after this attempt, I would have expected further meetings in order to review any plans that they came up with.

Observation 5 – The lack of a management plan regarding his daughter’s care proceedings

67. It is my opinion that Mr D’s risk surrounding his daughter being taken into care could have been predicted. Paragraph 3.13 of the Carol Draper report (Bundle 4, section 1), noted that on the 7th December 2001: “*He told staff that they would not stop him self harming if he could not see his daughter.* On the 16th December 2001 (Paragraph 3.19 of the Carol Draper report, Bundle 4, section 1) it is noted: “ *he had a period of head*

banging, telling staff that he was missing his daughter”. Furthermore, it would appear that Senior Officer Hayward had prior notice of the potential importance of the phone call that Mr D was making on the 27th December 2001. He states (page 6, Section 5, Bundle 4): *“I remember Officer Leane coming to me asking if D could have a phone call. I asked him why and he explained to me that he was having problems. I think his children, from what I could recall, were going to be taken into care or something like that.* Senior Officer Hayward decided to give this phone call despite the potential seriousness of the information that Mr D may be finding out. Additionally, it is quite clearly evident that no management plan had been determined prior to this event as quite clearly, the staff underestimated the importance of the information that Mr D had just received and the potential impact that hearing his daughter would be taken into care would have on his suicide risk .

Observation 6 – The management of Mr D on 27.12.01

68. It is my opinion that the management of Mr D was inadequate immediately following the phone call.

69. As previously mentioned, Mr D had already stated that his risk would increase should his daughter be taken away. Yet on finding out that this had happened, Senior Officer Hayward’s response was to make an entry in the 2052 *“to keep an extra eye on him.”* (page 11, Section 3, Bundle 4). What does “keep an extra eye on him” actually mean? What information does this convey to staff reading the F2052SH documentation? How should they interpret this? It obviously doesn’t mean that they should increase the frequency of observation as this would have been increased and stated had this been the plan. I assume that it doesn’t literally mean that two people should check him every 15

minutes as this will not reduce the risk any less than if one person checked Mr D. Therefore, it is my opinion that the plan of *“to keep an extra eye on him”* is actually pointless. I cannot determine how this changes anything about the current plan at that time, which was 15 minute observations.

70. I am concerned about the way suicide risk was managed at the time. Carol Draper’s Interview with Senior Officer Hayward (Section, 5, Bundle,4) clearly evidence’s a major problem in so far as non-clinically trained staff (prison officers) in a Health Care Centre are making the most crucial of decisions, that surrounding observation levels. In this interview Carol Draper asked: *“Did you give any consideration to actually increasing that or have you got the opportunity to increase that in terms of as a Health Care Senior Officer without a doctor?”* SO Hayward replied: *“well, it is debatable because at the time there was an Agency Nurse there doing 15 minute watches. To be honest with you and wrong though it may seem, is that we have a lot of people threaten self harm. If I put an agency nurse on constant observations on every inmate because he is a bit vulnerable then we would have a whole landing of agency nurses. Knowing D from what I did, he was always a little bit demanding as such and keeping himself in the limelight to a certain degree so therefore I thought no, the agency nurse is there, they are going to keep an eye and I will discuss it with a doctor, get the doctor to go and see him. Literally from what I can remember, it seems like just after I put the entry in, but obviously with the timings, there was a little bit of time in between, then I heard the agency nurse shout and the whistle go. I don’t know, I believe it was David Leane who blew the whistle, I am not sure. I am not sure. Then went down to the cell and saw that D had suspended himself from his light fitting.*

71. It would appear to me that SO Hayward hasn't answered the question posed. However, it seems to indicate that SO Hayward did have the option of increasing the observations if he felt it necessary.
72. I am particularly concerned with the following statement from SO Hayward: "*To be honest with you and wrong though it may seem, is that we have a lot of people threaten self harm. If I put an agency nurse on constant observations on every inmate because he is a bit vulnerable then we would have a whole landing of agency nurses*". I believe that SO Hayward has implied that he thinks that is wrong not to have everyone on constant observation. I absolutely agree that it is wrong. If prisoners need constant observation, then it should be provided irrespective of how many agency nurses are on the landing. The need to preserve life should come before any other consideration. I do not understand why, if it is deemed necessary, based upon the identified risk that a person poses and that risk alone, why the whole landing isn't full of agency nurses if it is deemed necessary. It suggests that SO Hayward is operating some sort of screening process as to how many agency nurses should be present irrespective of the prisoner's need. I am not sure what criteria SO Hayward uses to make these decisions, or indeed, what training he has had on clinical risk assessment to assist him with his decision making.
73. Additionally, I am concerned that non-clinically trained staff are placed in a position where they are making crucial decisions about a prisoner's level of risk. Senior Officer Hayward states: "*Knowing D from what I did, he was always a little bit demanding as such and keeping himself in the limelight to a certain degree so therefore I thought no, the agency nurse is there, they are going to keep an eye*". SO Hayward is clearly

making crucial decisions about Mr D and why he behaves the way he does. The above sentence takes no account of the fact that Mr D may have been suffering from a mental disorder and represents, what I believe is an opinion that I would expect from someone who is not a trained mental health professional. It is my opinion that the Inquiry should carefully consider the level of responsibility and power that non-mental health trained professionals have in the decision making of prisoners who are more than likely not, to have a mental health disorder.

74. Finally, it is apparent that there are differing accounts regarding the communications that occurred with the agency nurse following the phone call. I am unable to infer what actually occurred. However, in my opinion, I would consider the verbal communication to the Agency Nurse (a trained nurse) absolutely imperative in managing Mr D's risk, before anything is recorded in writing.

Opinion

75. As a preface to providing my opinion, it is worth noting that I have had to review Mr D's care and treatment with limited documentation. However, given this limitation, I believe that the opinion that I give is as full as possible.
76. It is important to note that sadly, sometimes professional practice is not always as it should be. The acute demands of the service at any given time can outweigh the ability of the clinical staff's or prison officers ability to ensure best practice at all times and even follow policies. Nonetheless, it is my opinion that the manner in which Mr D's care and treatment was managed fell well below acceptable standards even considering the acute demands of working in a Prison Health Care Centre. Furthermore, I believe

that the manner in which his individual case was managed raises a number of serious concerns as to the way in which prisoners were cared for in Pentonville Prison in 2001.

I will now deal with the specific questions that I have been asked to address.

Was there a risk to D's life on the facts of his case as known?

77. There was a clear risk to D's life, and these were known. As a general rule of thumb, most clinician's consider past behaviour to be a relatively good predictor of future behaviour. Most clinicians would consider self harming and suicidal behaviour as a key indicator for future self harming and suicidal behaviour. In my opinion, the fact that there were at least 16 separate occasions where Mr D had verbalised or acted in such a manner in a period of 30 days, then there clearly good evidence at that time, that he was a risk to himself.

What was the nature of that risk?

78. Quite clearly, the risk was of serious self harming or attempted suicide. As previously mentioned in this report, paragraph 3.13 of the Carol Draper report (Bundle 4, section 1), noted that on the 7th December 2001: *"He told staff that they would not stop him self harming if he could not see his daughter.* Thus, Mr D had quite clearly stated what would happen if his daughter was taken away. I therefore cannot understand why this was not pre-empted and a management plan developed given the possibility that this could occur.

Were the means being used to deal with the risks adequate and if not why not? And what could and should have been done?

79. No. From the information available, it is my opinion that the means by which Mr D's risks were managed were inadequate. Mr D should have been seen urgently by a Psychiatrist when one was urgently requested. When it became clear that this hadn't happened (e.g., after a maximum of 2 weeks) then the referring Dr (Dr Ranaweera) should have followed this up and made sure that it occurred. The Carol Draper interviews of the two interviewed doctors suggests that a high proportion of referrals for psychiatric assessment are marked "urgent" assessment. However, I do not believe that this changes the fact that Mr D required an urgent assessment. In my experience, there are a high number of people in any prison health care centre who require an urgent psychiatric assessment.. This is the case for most prison health care centres. The fact that a lot of people require an urgent assessment does not, in my opinion, reduce the urgency of that request. It merely reflects the realities of prison health care - that most prisoners in health care centres are in need of urgent Psychiatric assessment, care and treatment. Even in the absence of an urgent Psychiatric assessment having taken place, it is my opinion that the Responsible Doctor for Mr D's care, should have noticed this in each of the stated clinical reviews and followed this up to ensure that an assessment took place. In my opinion, Dr Yisa should have reconsidered his opinion and formulation of Mr D following the psychological assessment by Dr Halsey on the 18th December (9 days prior to Mr D's attempted suicide) who again recommended that an urgent Psychiatric assessment take place in Mr D's IMR. I would have expected, given Mr D's clinical presentation at that time, that had a Psychiatrist assessed him, that any reasonable body of Psychiatrist's would probably have concluded that Mr D was suffering from psychotic symptoms. I would therefore expect any reasonable body of Psychiatrists to therefore review Mr D's medication and commence a clear medication treatment regime for those psychotic symptoms. Given Mr D's presentation, I would

have expected any reasonable body of Psychiatrists to have administered anti-psychotic medication. I would also expect any reasonable body of Psychiatrists to administer such medication under the rationale that it was indicated for psychotic symptoms and not for a sleep disorder (as anti-psychotic medication is not indicated for sleep disorders and can actually cause insomnia). It is not possible for me to state exactly what that medication should have been, given the lack of clear clinical information, but I believe that given the information that I have had access to, that any reasonable body of mental health trained clinicians would probably indicate that such medication should have consisted of, at the very least, anti-psychotic medication, probably coupled with antidepressant medication. Additionally, thereafter, I would expect that any reasonable body of Psychiatrists to have regularly reviewed Mr D to monitor his response to such medication. I would also expect that any reasonable body of Psychiatrists would have considered the possibility of transfer to a Secure Psychiatric Hospital had Mr D not responded to such medication.

80. I would have expected that a more proactive approach should have been taken in relation to the possibility of Mr D's daughter being taken into care. I would have expected that a clear management plan was in place to support Mr D. At the very least, I would have expected that such a management plan should have existed as means of assisting staff as to what to do, should such an event happen. Had Mr D been in a Hospital then I would have expected much more from the clinical staff. Indeed it could be argued that much more should have been done and could have been expected by HMP Pentonville at that time, given that health care in prisons was supposed to be equivalent to that of the NHS. Specifically, I would have expected that Mr D should have had a Social Worker appointed to his case. I would expect that this Social Worker

would have then liaised with whoever was necessary to determine the family situation and report to the Clinical Team. I would expect that the Social Worker would probably have determined that there was a real risk of Mr D's daughter being taken into care. Should this have occurred, I would then expect any reasonable Clinical Team to try and prepare Mr D for this eventuality before it occurred. I would expect that any reasonable Clinical Team would have then, at the very least, have informed Mr D that a risk of his daughter being taken into care was a possibility. I would expect that any reasonable Clinical Team to carefully consider how to assist Mr D with how to cope should this happen and devise a care plan to inform staff what to do.

81. Even, without the proactive approach that I have just outlined, at the very least, I would have expected a care plan to assist those working with Mr D. It is my opinion that such a care plan should have been in place and should have detailed exactly how Mr D should be cared for and managed should he find out that his daughter was taken into care. I would expect such a care plan to have specified that he should be nursed on a 1-1 basis until the clinical team that was responsible for his care had had an opportunity to review Mr D. Even without such a care plan, I would have expected that the Senior Prison Officer should have increased Mr D's observations to 1-1 (irrespective of how many agency nurses would be in the health care centre at that time), as soon as he was made aware that Mr D's daughter had been taken into care. Again, even without a care / management plan in place, I would expect that the Senior Prison Officer would have made absolutely certain that the observing nurse had been informed that Mr D's daughter had been taken into care in order that that nurse could then use her professional judgement as to how best to care for him in that situation.

82. Finally, I would like to state my belief that it should have been psychiatric nurses (in conjunction with psychiatrists - and if Psychiatrists were not available then Medical Officers) making the day to day decisions about the observations levels that Mr D should have been on and not Prison Staff who are not trained mental health professionals. I would respectfully urge the Inquiry to consider this issue carefully. Why were Prison staff, who are concerned primarily with security, making crucial health care decisions, when it is clear that trained health care professionals were present? When considering the report produced by Her Majesty's Chief Inspector of Prisons in 1996, 5 years prior to Mr D's attempted hanging, entitled "Patient or Prisoner?", the question as to why Prison Officers and not nurses were making decisions about a person's care and observation levels suggests that the culture of HMP Pentonville in 2001, considered the role of security as more important than that of health. The actions of the staff involved at that time suggests a culture that does not appear to take into account the main principle as laid down by Her Majesty's Chief Inspector of Prisons in 1996, in so far that the report emphasises the importance of treating those who are ill in prison as patients rather than prisoners.



PROFESSOR PAUL ROGERS


PhD, MSc (Econ), RN, Cert ENB 650 Beh Psychotherapy, Dip Beh Psychotherapy
Professor of Forensic Nursing

23rd June 2007

Declaration

I, Professor Paul Rogers, declare that:

- ◆ I have set out in my report what I understand from those instructing me to be the issues in respect of which my opinion as an Expert is required;
- ◆ I have done my best in preparing this report to be accurate and complete. I have mentioned all matters that I regard as relevant to the opinions I have expressed;
- ◆ I have drawn to the attention of the Inquiry all facts, of which I am aware, that might affect my opinion;
- ◆ I have not included anything in this report that has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter;
- ◆ At the time of signing the report, I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification;
- ◆ I understand that this report will be the evidence that I would be prepared to give in an Inquiry, subject to any correction or qualification I may make before swearing to its correctness;
- ◆ I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case;
- ◆ I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct;
- ◆ I confirm that, insofar as the facts stated in my report are within my own knowledge, I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

Signed..... 

23rd June, 2007.....

Appendix 1 – Background of Professor Rogers

I have over 20 years experience of psychiatric nursing in inpatient and outpatient settings, including prison settings. I also have experience of conducting mental health assessments of prisoners, both as a psychiatric nurse and also as a Cognitive Behaviour Therapist (including treating prisoners using Cognitive Behaviour Therapy in Prison settings). I am currently employed as a Professor of Forensic Nursing which is a joint position between the University of Glamorgan and an NHS Trust.

I have specific experience relevant to Prisons. In 1996, I wrote a paper relating to the need for Prison Health Services to be provided by the NHS: “Rogers, P. and Topping Morris, B. (1996). *Does the prison service need forensic mental health Nursing? Nursing Times*, 92(31), 31-34”. In 1997, I published a paper about a male rape in a prisoner “Rogers, P. (1997). *Posttraumatic stress disorder following male rape. Journal of Mental Health*, 6(1), 5-9”. In 2003, I wrote a paper on how to care for prisoners with posttraumatic stress disorder for the Prison Service Journal: “Rogers, P. Mitchell, D., Duggan, S, Curran, J. & Gournay K. (2003). *Posttraumatic stress disorder: Nature, treatment and issues to be considered when caring for prisoners. Prison Service Journal*, 146, 24-30”. In 2004, I co-authored a paper describing a Prison In Reach Mental Health Service in the South West of England: “Emslie, L., Coffey, M., Duggan, S., Bradshaw, R., Mitchell, D. & Rogers, P. (2004). *Including the excluded: developing mental health in-reach in southwest England. Mental Health Practice*, 8(6), 17-19”. In 2005, I wrote a paper discussing the modernisation of Prison Health: “Duggan, S., Bradshaw, R., Mitchell, D. Coffey, M. & Rogers P. (2005). *Modernising prison mental health. Professional Nurse*, 20(8), 20-22”. In 2006, I wrote a paper describing work that was ongoing on the modernisation of prison health in the Republic of Georgia: “Rogers, P., Keukens, R., Van Voren, R. (2006). *Reforming the delivery of forensic mental health and prison health in the Republic of Georgia. Mental Health Practice* 9(5), 38-40”. In 2007, I co-authored a paper describing the findings of a study into Cardiff Prison examining the associations between a history of mental health and parasuicide (suicide attempts and self harming): “Black, D., James, M., Evans, R., Rogers, P. (2007). *The association between a self reported history of mental health problems and a history of parasuicide in a sample of UK male prisoners. International Journal of Nursing Studies* 44(3), 427-434”.

Additionally, I have been involved in the commissioning of two guidance reports relating to mental health in reach into prisons: (1) Rogers, P. (2003). *Clinical Standards for Prison Mental Health In-Reach Teams: Report of the findings of the clinical standards Invited Reference. Commissioned by the Prison Mental Health In-Reach Collaborative. Presented to Prison Health (Department of Health/Home Office)*; (2) Williams, R. & Rogers, P. (2003). *Report of the launch of Prison Mental Health In-Reach Teams in Wales. The National Assembly for Wales*. I am a Steering group member of the Prison Health Research Network for England and Wales.

Additionally, I was involved in the commissioning process of the Health Care Centre at HMP Parc in Bridgend, South Wales. This was the first time that health care had been provided to a prison population by the NHS. In the time that the NHS managed this service, I was involved in the induction training of prison health care staff and the development of policies. I also clinically supervised senior Health Care staff so understand the day to day pressures of working in a Health Care Centre. I was involved in post incident debriefing sessions for staff following attempted suicides. Finally, I presented a proposal to the NHS Trust to establish a

Cognitive Behaviour Therapist with the Health Care Centre, which was accepted and I clinically supervised this person while working in the Prison. .

I have had a particular interest in inpatient care and the risk assessment procedures of harm to self and others. I have published research and peer reviewed papers related to suicide / self harm and associated book chapters on inpatient assessment and care. I have published papers on the association between command hallucinations, specifically voices telling a person to harm themselves and actual self harm attempts which is relevant to Mr D's symptoms: "*Rogers, P., Watt, A., Gray, N.S., MacCulloch, MM & Gournay, K. (2002) Content of command hallucinations predicts self harm but not violence in a medium secure unit. Journal of Forensic Psychiatry, 13(2), 251-262.*". My PhD examined the associations between command hallucinations and later violence

I recently led a thematic review of suicides by patients in contact with one NHS Trust in Wales taking a seconded nurse 4 months to complete. This involved a detailed analysis of 29 sets of clinical records. The final report documented 21 recommendations for improving the services offered to people with mental health problems. All recommendations were accepted by the NHS Trust and local NHS services.

I recently led a 14 month programme of modernisation and improvement funded by the Welsh Assembly Government through the National Leadership and Innovation Agency for Wales into one NHS Trust in Wales. The focus of this work was to examine and improve Crisis Resolution and Home Treatment within the Trust. Most of the client's referred to this service were either suicidal or self harming.

I am currently involved in developing training courses for multi-disciplinary mental health staff on a range of evidence based risk assessment tools. The development of these training courses is funded by the Welsh Assembly Government.

I have held a range of honorary and appointed positions related to psychiatric nursing. Between 1998 and 2001 I was an External Nurse Reviewer for The Health Advisory Service 2000. From 2001 to present, I have been a Nurse Clinical Governance Reviewer for Commission for Health Improvement / Healthcare Commission. From 2001 to present, I have been an External reviewer for the Accreditation Unit, Royal College of Nursing. From 2002 to present, I have been a member of the Expert Reference Panel for the Nursing & Midwifery Council. In 2006, I was on an expert advisory group for the National Patient Safety Agency determining the definitions of suicide by patients in the care of the NHS to assist in determining future standards for investigating such cases. I am a member of the Risk Assessment Tools Expert Advisory Group (England) which reports to the National Mental Health Risk Management Programme through the Care Services Improvement Partnership and the London Development Centre. I am an external Expert Steering Group Member for the Dangerous and Severe Personality Disorder programme. I am a Steering group member on the National Institute for Clinical Excellence's guidelines on Anti Social Personality Disorder. I am Steering Group Member of the Welsh Assembly Government's review of Secure Services in Wales.

I was elected as an Associate Member of the Royal College of Psychiatrists on the 24th February 2004. From 2002 to 2004, I was elected President-elect of the International Chapter of the American Psychiatric Nurses Association and from 2004 to present, the President of the International Chapter of the American Psychiatric Nurses Association. In 2007 I was a

Steering committee member of the American Psychiatric Nurses Association's (APNA) Seclusion and Restraint Task Force. The 23 steering group committee has synthesized input from the larger consultant group (of over 100 US nurses) to determine what is needed to update the APNA publication: "*Seclusion and Restraint: Position Statement and Standards of Practice*".

In addition, I have held a range of academic positions related to psychiatric nursing. I have been an editorial board member for "Mental Health Practice" from 1997 to present. I have been an editorial board member for the "Journal of Forensic Psychiatry & Psychology" from 2003 to present. I have been an editorial board member for "Criminal Behaviour and Mental Health" from 2004 to present. I have been an editorial board member of the Journal of Mental Health Workforce Development from 2006 to present. I was the recipient of the Professor Annie Altschul International Publication Prize in Mental Health Nursing in 2001.

Appendix 2 - Documents studied:

BUNDLE 01

Terms of Reference

List of Issues

Procedure Document

First Instance Decision before Munby J – 28th April 2005

Court of Appeal Decision before Sir Anthony Clarke MR, Lord Justice Tuckey, Lord Justice Dyson

Prison Service Instructions Number 20/2004

BUNDLE 1

Incident Report Forms various for 3rd, 13th, 27th December 2001, memos relating to events of 27th December 2001 and Radio Log

Register of F2052SH.

Inmate Information System Records.

Correspondence from Tower Hamlets Health Care NHS Trust to Dr Haque, 'D's GP dated 10th August 2000

Extracts from Information Book - December 2001

Report of Injury to Inmate (Form WT001) 13th December 2001

Correspondence March 2002 to January 2003.

- Barnet, Enfield & Haringey Mental Health NHS Trust
- East Lynne Medical Centre, Clacton-on-Sea
- Royal Free Hospital
- Speech & Language Therapy Unit, Clacton Hospital
- Colchester Hospital
- Camden & Islington Mental Health NHS Trust
- St Andrew's Group of Hospitals, Northampton
- Green Elms Health Centre
- Treatment & Progress Report compiled by Royal Free Hospital

Medical Report, Mental Health Tribunal Report 2nd June 2003.

Redacted letter from Paul Parry, Healthcare Principal Officer 23rd March 2004

Note of Discharge Planning Meeting Kemsley West Ward 8th July 2004

Record of Hearing & Adjudication. 04 December 2001

Referral for Psychiatry / Psychology

Dr Robert Halsey letter to Dr Ranaweera. 4 December 2001

Dr Robert Hasley letter to Dr Ranaweera. 25 January 2002

BUNDLE 2

Summary 2006 Abani, Beatrice

Summary 2006 Ansong, Emmanuel

Transcript 2006 Ansong, Emmanuel

Summary 2006 Attard, John

Transcript 2006 Attard, John

Summary 2006 Boateng, Shirley

Transcript 2006 Boateng, Shirley

Draper summary Chikuku, Phoebe

Draper transcript Chikuku, Phoebe

Interviewed by Stephen Shaw - Draper, Carole

Summary 2006 Davies, Gareth

Transcript 2006 Davies, Gareth
Draper summary Halsey, Robert
Summary 2006 Halsey, Robert
Transcript 2006 Halsey, Robert
Summary 2006 Hayward, Peter
Transcript 2006 Hayward, Peter
Draper summary Hayward, Peter
Draper transcript Hayward, Peter
Summary 2006 Japaul, Vicky
Transcript 2006 Japaul, Vicky
Summary 2006 Kringle, Ruth
Transcript 2006 Kringle, Ruth
Summary 2006 Leane, Dave
Transcript 2006 Leane, Dave
Draper summary Leane, Dave
Draper transcript Leane, Dave
Summary 2006 Murray, Doug
Transcript 2006 Murray, Doug
Draper summary Murray, Doug
Draper transcript Murray, Doug
Summary 2006 Parry, Paul
Transcript 2006 Parry, Paul
Summary 2006 Ranaweera (Dr), Vasantha
Transcript 2006 Ranaweera (Dr), Vasantha
Summary 2006 Richards, Peter
Transcript 2006 Richards, Peter
Draper summary Richards, Peter
Draper transcript Richards, Peter
Summary 2006 Smith, Tony
Transcript 2006 Smith, Tony
Draper summary Yisa (Dr)
Draper transcript Yisa (Dr)

BUNDLE 3

Witness statement of Gareth Davies (“GD”)
Exhibit GD1 – Table of Self Inflicted Deaths at Local Prisons 1996-2007
Exhibit GD2 – Prison Service Instruction 15/2001 Mandatory Training 2001-2002
Exhibit GD3 – Prison Service Instruction 32/2006 Personal Issue Cut-Down Tools Issued November 2006
Exhibit GD4 – F2052SH Self Harm at Risk Form, undated
Exhibit GD5 – Prison Service Order 1025 Communicating Information about Risks on escort of transfer – The Prisoner Escort Record Issued September 2000
Exhibit GD6 – Prison Service Order 0550 Prisoner Induction Issued August 2000
Exhibit GD7 – Action Plan arising from the attempted suicide of ‘D’ 27 December 2001, undated
Witness statement of John Attard (“JA”)
Exhibit JA1 – Extracts from Observation Book December 2001
Exhibit JA2 – healthcare Centre Manager’s Action Plan, reviewed 31 October 2000
Exhibit JA3 – HM Prison Service/NHS Healthcare Protocol regarding levels of observations 18 May 2003

Exhibit JA4 – Report by John Attard regarding the classification of prisoners in healthcare 8 October 2000
Exhibit JA5 – Basic Prison Trauma and Life Support Training Notes, undated
Exhibit JA6 – Draft Protocols for Mobilising the Emergency Medical Response Team, undated
Exhibit JA7 – Minutes of Suicide Prevention Committee Meetings October 2001 – March 2002
Exhibit JA8 – Self Audit Table and Self Audit Sheets March 2001
Exhibit JA9 – Summary of Proposed Action and Draft Action Plan following Internal Audit March 2001.

BUNDLE 4

Carole Draper Report
Annexe - Incident Report
Annexe - Transcript of Interview: Agency Nurse Chikuku
Annexe - Transcript of Interview: Officer Leane
Annexe - Transcript of Interview: HSCO Hayward
Annexe - Transcript of Interview: Officer Murray
Annexe - Transcript of Interview: Officer Richards
Annexe - Transcript of Interview Dr Yisa
Annexe - Note of a meeting with R Halsey, visiting clinical psychologist

BUNDLE 5

HMI. Suicide is Everyone's Concern May 1999.
HMI. Inspection of HM Prison Pentonville October 1999.
HMI. Annual Report 1999-2000 Extract.
HMI. Annual Report 2001-2002 Extract.
HM Pentonville Board of visitors Annual Report 2001.

BUNDLE 6

HMP Pentonville Board of Visitors Annual Report 2002
HMI Annual Report 2002-2003.
HMI. Follow up Inspection HM Prison Pentonville September 2002.
HMI. Annual Report 2003-2004. Extract
HMI. Report on Inspection HM Prison Pentonville January 2005.
HMI. Annual Report 2004-2005.

BUNDLE 7

HMI. Annual Report 2005-2006.
HMI. Report of Inspection June 2006.

BUNDLE 8

Prison Service - Health Care Standards for prisons in England and Wales, undated
Prison Service - Standing Order 13: Health Care, April 1991.
Prison Service- Database of Prison Medical Officers, HM Prison Pentonville. 28 April 1997.
HMP Pentonville – final draft Health Care Needs Assessment, [1999-2000]
HMP Pentonville – Guidelines for Allocating Patients to Full Time Prison Clinicians and Referrals to Visiting Specialists
HMP Pentonville – Guidelines for Allocating Patients to Full Time Prison Clinicians and Referrals to Visiting Specialists: Memorandum, June 1991

Prison Service - Senior Medical Officer: Role description, Duties and Responsibilities.
Prison Service- F2052SH. Self Harm at Risk form.
HMP Pentonville – Suicide Prevention Team – Policy Document 2001: Caring for prisoners at risk of self harm or suicide.
Prison Service Order number 2700 – Suicide and Self Harm Prevention [Date of issue 4 November 2002].
Prison Service - Prison Health Handbook, revised January 2003.
Prison Service Instruction 51/2003 PSO 2700: Suicide and Self Harm Prevention. Warning form for use by escort staff. 12 January 2004.
Prison Service Instruction 18/2005. Introducing ACCT. [The replacement for the F2052SH] 10 May 2005.
Prison Service – Mental Health Observation, including Constant Observation: Good Practice Guidelines for healthcare staff working in prisons. August 2006.
UK Government response to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment [CPT] February 2001.

I have not seen Bundle 9

BUNDLE 10

IMB (Pentonville Board of Visitors) 2004 Annual Report. April 2003-March 2004.
IMB (Pentonville Board of Visitors) 2005 Annual Report. April 2004-March 2005
IMB (Pentonville Board of Visitors) 2006 Annual Report. April 2005-March 2006
Prison Service Instruction 032/1997 the Role of the Samaritans. April 1997-April 1998
Prison Service Instruction 27/2000 Eliminating Strip Cells. 30 March 2000
Prison Service Instruction 66/1998 Introduction of the Prisoner Escort Record 25 January 1999
Prison Service Instruction 69/2000 Basic Checks on Doctors and Dentists 5 December 2000.
Prison Service Instruction 38/2003 Basic Checks on Doctors and Dentists 15 August 2003.
Health Services for Prisoners: Key Performance Standard. September 2001
Health Services for Prisoners: Key Performance Standard. July 2002.
Health Services for Prisoners: Key performance standard. May 2004
Prison Service Instruction 43/2003 Issue of the Healthcare Skills Toolkit 10 October 2003.
Prison Service Order 8200 Staff Training and Development: Central and Local Planning and Management. 12 April 1999.
Prison Service Instruction 43/1999 POINT Training and Probation Period for Officers. 15 June 1999
Prison Service Order 8150 Prison Service Post Incident Care for Staff 11 June 1998
Prison Service Instruction 28/1998 Post Incident Care for Staff. 11 June 1998
Prison Service Instruction 33/2000 Post Incident Care for Staff. 27 April 2000
Prison Service Instruction 13/2000 Post Incident Care for Staff. 1 March 2000
Staff Care and Welfare: Key Performance Indicator. 20 April 2002
Staff Care and Welfare: Key Performance Indicator. June 2004
Prison Health Policy Unit and Task Force Annual Report 2000/2001 November 2001
Prison Service Instruction 05/2001 Extra Payments for Type 3 and 4 Healthcare Centers. 1 March 2001
Prison Service Order 3200 Health Promotion. Undated but updated 23 October 2003
HMPS Standing Order 1A Reception Procedures. May 1990
Prison Service Order 0500 Reception. 11 June 2004
Instruction to Governors 1/1994 Caring for the Suicidal in Custody 3 February 1994

Instruction to Governors 79/1994 Caring for the Suicidal in Custody 24 November 1994

BUNDLE 11

HMPS Thematic Review: Caring for the Suicidal in Custody. 1997
HMPS Prisoners Information Book. 2002
Prison Health Bi-Annual report 2001-2003. December 2003.
Developing and Modernising Primary Care in Prisons. June 2002.
Prison Service Order 3550 Clinical Services for Substance Misusers 20 December 2000.
Prison Service Instruction 8/2001 Prison Service Drug Strategy 20 February 2001.
Clinical Governance-Quality in Prison Healthcare. 16 January 2003.
Prison Service Instruction 27/2006 Prisoner Induction Healthcare 31 August 2006.
Prison Service Instruction 48/2003 Guidance for the Introduction of Health Care Assistants. 16 October 2003.
Prison Service Instruction 52/2002 F213SH for Self Harm/Attempted Suicide and Changes to the Recording on IRS System. 1 December 2002.
Prison Service Instruction 10/2004 Issue of a Model Induction Framework for Healthcare Staff. 28 February 2004.
Prison Service Instruction 03/1997 Security and Standards Audit Action Plans 23 January 1997.
Standards Audit: Key Performance Standard. July 2005.
Prison Service Order 0250 Standards Audit. 20 July 2005.
HMPS Internal Review Prevention of Suicide and Self Harm in the Prison Service. Published 2001.

BUNDLE 12

HMP Pentonville Guidance regarding first night centre and Induction, roles of governors, officers, medical officers, healthcare staff, Samaritans and listeners.
Prison Service Instruction 05/2003 Good Medical Practice for Doctors Providing Primary Care Services in Prison. 24 January 2003
Prison Service Instruction 51/2003 Suicide /Self-Harm Warning 12 January 2004
Department of Health. Offender Mental Health Care Pathway. January 2005
Prison Service Instruction 22/2000 Training Plan 1 April 2000
Prison Service Instruction 29/2001 Amendment to PSI 15/2001 Mandatory Training. 17 May 2001
Prison Service Instruction 24/2002 Health Promoting Prisons: A Shared Approach, A Strategy for Promoting Health in Prisons in England and Wales 24 May 2002
Prison Service Instruction 36/2002 Developing and Modernising Primary Care in Prisons. 23 July 2002
Extracts from HMP Pentonville Governor's Journal - 27 and 28 December 2001
Extracts from HMP Pentonville Visitors Book – 11 December and 13th December 2000.
HM Prison Service Final Report of a Combined Standards and Security Audit at HMP Pentonville. 28 January to 12 February 2002
Report into the death of Mr Mabhena on 10 October 2001.
Report into the death of Mr Clarke on 28 December 2001.
Report into the death of Mr Newman on 8 July 2002.

Appendix 3 - Literature pertaining to command hallucinations

During my PhD, I conducted a thorough literature review. For the purposes of my PhD I Searched MEDLINE (1966-2002), PSYCHLIT (1974-2002) and key Mental Health and Forensic Mental health texts books for literature pertaining to command hallucinations. Numerous descriptive case reports were found in the literature which suggested a positive relationship between command hallucinations and the risk of: sexual offending (Pam & Rivera, 1995); violence to others (Good, 1997); self amputation of a limb (Hall et al, 1981); self amputation of the penis (Hall et al, 1981); swallowing objects (Karp et al, 1991); self mutilation of the eyes (Field & Waldfogel, 1995); self inflicted lacerations (Rowan & Malone, 1997); and suicide (Zisook et al, 1995). Only limited information and conclusions can be taken from these non-comparison studies.

Prior to 2000, three systematic reviews were conducted. None of these reviews included meta-analytical procedures. All concluded that there was no evidence for an association between command hallucinations and violence and or self-harm.

The first review was conducted in 1988 (Rogers, Nussbaum, & Gillis, 1988) and was based upon one study. The review concluded that the relationship between command hallucinations and violent behaviour was scarce and fragmented. More recently, two further reviews arrived at similar conclusions.

The second was conducted by Hersh and Borum (1998). This review allowed for a wide definition of the outcome measure and used “dangerousness”. This ranged from non-violent criminal behaviour (e.g., suicidal ideation) to life-threatening behaviour. The authors concluded that there was no association between command hallucinations and any form of dangerousness. Interestingly, despite their review findings they suggested that some patients do comply with command hallucinations and clinical risk assessment should include assessment about the presence of command hallucinations.

The third review was conducted by Rudnick (1999). This review found nine studies. Rudnick again used “dangerousness” as an outcome that included violence toward others and violence toward self. Rudnick examined these separately. Rudnick concluded that there was no association between command hallucinations and either violence or self-harm. Rudnick reported that all of the controlled studies were methodologically weak which means that the conclusions drawn from them should be tentative. Rudnick presented the notion that future studies should scrutinize aspects of the content of the command hallucinations as well as the mere presence. Three studies have examined such associations since that recommendation.