Investigation into the circumstances surrounding the death of a female prisoner at HM Prison Durham in May 2004

Report by the Prisons and Probation Ombudsman for England and Wales

July 2004

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1. Introduction

This is the report of an investigation into the circumstances surrounding the death of a female prisoner at Durham Prison on 8 May 2004.

A post- mortem examination carried out on 11 May 2004 concluded that the cause of the prisoner's death was pressure on the neck due to hanging.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service which came into effect on 1 April 2004. In keeping with that agreement a Senior Investigating Officer (SIO) carried out the bulk of the investigative work on my behalf and under the guidance of my colleague. The SIO's examination of the circumstances that preceded the prisoner's death, together with his findings, are recorded in full in his report in Section 5. My thanks go to him and his assistant. I have structured this report in such a way that the SIO's investigation can be separately identified.

The terms of reference for the investigation can be found in Section 5 at paragraph A1.

I commissioned an independent clinical review of the management of the prisoner's healthcare needs during her time in custody. This was carried out by a representative of the Durham and Chester-le-Street Primary Care Trust, to whom I am most grateful.

The findings in the SIO's report are summarised in Section 3 below.

I have drawn the conclusion that the prisoner was appropriately cared for whilst she was at Durham Prison and that little could have been done to prevent her tragic and untimely death. That said, in consultation with the Senior Investigating Officer, I nevertheless make one observation and three recommendations. These can be found in Section 4.

2. Summary

The deceased

The prisoner was born in 1958. She was the last of four siblings, born to a 44 year old mother from whom she would become estranged by the time she was 20. She had listed her next of kin as her partner. After leaving school the prisoner took on various jobs as a post woman, computer data in-putter, cleaner, worker in a rubber factory, and most recently, traffic warden. However, she was in the habit of drinking heavily and, in 1982, began to break the law. Her offences were varied and she was given a variety of custodial and non custodial sentences. At the time of her death, she was serving a 10 year prison sentence.

On entering prison in December 2002, the prisoner told reception staff, wrongly, that she had not previously tried to harm herself. During her current sentence, she became subject to self-harm monitoring procedures (through the use of the form F2052SH) on six different occasions between May 2003 and the day she died. She had often become depressed, had occasionally talked about taking her life, and, on one occasion in August 2003, had actually tried to hang herself. The last time self-harm monitoring procedures had started was on 20 April 2004. The procedures were ended on 5 May 2004, three days before she died.

On the last day of her life, the prisoner gave no obvious signs that she was contemplating suicide. She was last seen alive at approximately 12:10pm that day by another prisoner whom she had befriended. That prisoner had talked to her through the observation panel in her cell door just before lunchtime and had promised that she would return to see her in the afternoon so that they could cook some food together. It was when that prisoner returned at about 1.30pm that she discovered her friend hanging. The staff who responded found the prisoner slumped on the floor of her in-cell toilet with a ligature suspended from the handle of the door. There were no obvious signs of life. They removed the ligature and attempted to revive her but without success. A nurse arrived and continued to apply resuscitation techniques, again without success. No heart-start equipment or oxygen was brought to the cell. Soon after, paramedics arrived and took over from prison staff. At 2.20pm, the prison doctor certified the prisoner dead.

Previous deaths of women at Durham

This prisoner was the sixth woman to die, apparently at her own hand, at Durham since 19 August 2002. In the financial year 2003/2004, 14 women died in prison. Between 1 April and 7 May 2004, five women had already died. The alarming increase in the rate at which women in prison are dying apparently by their own hand is a trend about which I am especially concerned. I have therefore decided to refer to an advisory committee (that I shall chair with the Head of the Women’s Team in the Prison Service) the findings of all my investigations into the deaths of women prisoners in order to highlight any features which might be common in some or all of the reports, and to promote any good practice found. Once the committee is established, this will be done while the investigation is at draft stage.

Durham Prison
Durham Prison opened in 1819 and was rebuilt in 1881. Since then, it has maintained its primary role as a local prison serving courts in the Northeast. The prison holds male and female prisoners. Both the male and the female sectors of Durham prison have, until recently, been managed by the Director of High Security Prisons.

During the period of the investigation, an announcement was made, purely by coincidence, that the Prison Service had decided to close the Women's facility at Durham.

3. Findings and Conclusions

3.1 The findings and conclusions drawn from the SIO's report are summarised as follows:

Ligature
The deceased prisoner had apparently found the ligature used by another prisoner to hang herself at Durham in November 2003 and had told staff how stressed and unnerved she was by this experience. This may have had an adverse impact upon her propensity for self-harm. She was placed on a F2052SH on 20 November 2003 when she told staff that she was jealous of the deceased prisoner because "she was in a better place".

The ligature found on the prisoner's body on 8 May 2004 was flimsy, having probably been crafted from the drawstrings of her nightwear. The chosen anchor point for the ligature was the inside handle of the toilet door, a position which meant that the prisoner was unsighted to any member of staff who chose to look through the observation panel into the toilet area of her cell.

Staff
The view of the investigators that staff seemed to adopt a very proactive and positive approach to the prisoners in their charge was shared by a number of prisoners who were interviewed. Unlike the conclusions drawn from a short inspection of Durham by HMCIP in January 2003 the investigators could find no evidence that staff shortages or other pressures sometimes meant that prisoners' concerns could not always be dealt with. Neither was there any evidence to support any idea, as had been expressed in other Inspection reports, that staff were sometimes so preoccupied with a handful of difficult prisoners that they were unable to give full attention to some of the less demanding but equally needy prisoners. The staff complement in the Women's prison at Durham at the time of the investigation showed them to be at full strength. The layers of staff from the managers, to the landing officers, to the safer custody staff, to the medical staff, to the probation and psychology staff all seemed to operate as a pretty well trained and effective team. No serious criticism could be levelled at the staffing aspect of the Women's unit.

Self-harm monitoring procedures (F2052SH)
The prisoner arrived at Durham on 21 August 2003. A form F2052SH had been opened on 4 occasions whilst she was there. She regularly expressed her unhappiness whenever this was done. The last time a F2052SH was opened for her was on 20 April after she had handed to staff a ligature she had made. The document remained opened open until 5 May, three days before her death. The prisoner attended her own case review that day and agreed with the views of staff that it could be closed. Those staff were unaware of the fact that the prisoner had just been sacked from her job as a servery orderly after losing her temper. Neither were they aware of the possibility that the prisoner was in the second day of a food refusal. Despite the fact that the review panel's decision to remove the prisoner from F2052SH monitoring subsequently proved to be premature, it was nonetheless hard for the investigators to suggest that the panel had made a mistake at the time, given what they could reasonably have been expected to know.

Attendance on the Dialectic Behaviour Therapy Course and the prisoner's relationships with other prisoners
From the end of January 2004 to the time of her death, the prisoner was registered as a participant on the Dialectic Behaviour Therapy (DBT) course. The course tutor had painted a picture of her as a highly complex character who was given to threatening self harm as a means of fulfilling her own needs. The prisoner had once said to her tutor that "people speak nicely of you when you are dead." It was the opinion of the tutor that the prisoner's relationship with another prisoner in the same wing created for her the most intense moments of highs and lows. A member of staff interviewed by the investigators expressed the view that the prisoner became jealous of her friend if she appeared to spend too much time with anyone else. On the day of her death, the prisoner had asked her friend to promise that she would go to her cell first at unlock after lunch. The investigators were unable to determine why the prisoner made such a specific request.

Loss of job on servery
On 4 May 2004, the prisoner lost her job on the wing servery because she had lost her temper and thrown a cup of coffee onto the landing after being told by an officer to return to her cell for a meal time roll check. This event affected her badly and may have been the reason for her entering into a period of food refusal and, possibly, into thoughts of self harm. In the view of the investigation team, the loss of her job was an appropriate reaction to her poor behaviour.

Medication
Prior to entering prison, the prisoner appears not to have been on any kind of medication. From May 2003 she took anti-depressants for 7 months and then decided to stop for 3 months. Two days before her death, the prisoner decided that she would like to return to the use of Prozac as other prisoners had suggested to her that she was moody. The prescription for this medication was not dispensed before her death.

Listeners and Issues of confidentiality
Staff and prisoners in the Women's unit at Durham expressed concern about the issue of Listener confidentiality. The close knit nature of the unit meant that Listeners were often friends of the people to whom they were listening. Listeners would sometimes hold sessions with prisoners where threats of self injury emerged, but the primacy of confidentiality prevented any warnings being passed on to staff.

Efforts to revive the prisoner
A Senior Officer and five other officers gave immediate attention to the prisoner once she had been discovered hanging. Shortly afterwards they were joined by a nurse from the establishment's healthcare centre. The ligature was removed, a pulse was searched for, and mouth-to-mouth resuscitation and heart massage were applied until the ambulance service took over. The investigation team offer no criticism at the way staff responded to the incident other than to point out that no "heart start" equipment or oxygen available in the healthcare centre was brought to the scene. It was felt by the investigators that this equipment ought to be a standard item brought to the scene whenever a life is threatened.

Institutional factors
The Senior Investigating Officer felt that any explanation for the prisoner's actions was likely to rest on more than one factor, including that of the establishment's experience of the deaths of other women at Durham in the preceding two years. The SIO felt ill equipped to understand fully the dynamic created by so many women ending their lives within one living area over a relatively short period but agreed with the decision of the Prisons Board, made during the currency of the investigation, to close the Women's unit at Durham.

Level of care shown to the prisoner
The Senior Investigating Officer felt unable to level any serious criticism of the systems and processes in place at Durham to prevent prisoner deaths. Neither did he feel justified in levelling serious criticism at the staff in the Women's unit who, he considered, carried out their work with care and compassion.

3.2 The conclusion drawn by the Chester-le-Street Primary Care Trust in the report of their clinical review is that "healthcare input was relevant throughout". No criticisms are offered in the report.

4. Observations and recommendations

4.1 Planned closure of the Womens' prison at Durham

On page 34, paragraph 11 of his report, the Senior Investigating Officer writes as follows:

…The dynamic of a mixed group of women living together in an enclosed environment, some with extremely complex problems and others with a

propensity for self harm where six self inflicted deaths had taken place in the last two years, was outside the level understanding that the investigators could bring to an inquiry like this. It was already recorded in this report that during the course of the investigation the Prisons Board had decided to close the Female Centre. The investigation team agreed with such a proposal as a means of breaking the cycle of female prisoner self harm. The prospect of the Centre closing obviously meant that the need to study the complex dynamic of females occupying a prison unit like F/G wing where a number of deaths had occurred, was redundant.

Observation 1

I agree that there is little to be gained from any further study of this particular unit but the Prison Service will itself recognise that whatever the benefits of the planned closure, the very process of the relocation of the current population will have a destabilising effect on some prisoners, and may present a further risk of self harm amongst those unable to cope with such a development.

4.2 Emergency equipment

The SIO draws attention to the fact that no oxygen or ''heart start'' equipment was taken to the prisoner's cell after she had been discovered hanging. It struck the investigating team that 'this equipment ought to be a standard item brought to the scene whenever a prisoner threatened their life'.

I agree.

Recommendation 1

At any time that it is clear that a life threatening incident has occurred in a prison the emergency equipment carried to that incident by staff responsible for responding should include oxygen and a defibrillator. Contingency plans in establishments and instructions to medical staff should make this clear.

4.3 Observation into cell areas

The SIO speculates that the prisoner may have deliberately chosen the ligature point used in order to evade any observation by staff.

Recommendation 2

The Prison Service should consider what further measures might be taken to facilitate the observation of those parts of cells (including the toilet area) which are currently unsighted to staff.

4.4 Managerial presence

The SIO comments that no senior manager attended the Women's wing when the prisoner was discovered hanging.

Recommendation 3

An appropriate operational senior manager should be present as soon as possible after the apparent death of a prisoner has been discovered.

5. SENIOR INVESTIGATING OFFICER'S REPORT

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A1. Terms of Reference

The Prisons and Probation Ombudsman requests the Senior Investigator Officer to investigate the circumstances of the death of a female prisoner at HM Prison Durham on 8 May 2004. You and other members of the investigating team act on my behalf in conducting the investigation.

The Investigators appointed by the Prison Service will be responsible for:-
Gathering and analysing evidence and information.
Conducting interviews.
Carrying out any necessary audits of policy and procedures.
Presenting to my investigator by 18 June 2004 a report of your findings and conclusions together with supporting documentary information, and details of the time and other costs incurred during the investigation.

My Investigator will liaise with you. I have asked him, in conjunction with you, to:-
Meet the Governor.
Meet representatives of the appropriate Trade Unions.
Meet representatives of the Independent Monitoring Board.
Make himself known to the Police and Coroners Office.
Secure Clinical Advise through the appropriate NHS Trust as necessary.
Inform the bereaved family of the investigation and seek to involve them in the investigation process.
Issue appropriate notices to staff and prisoners.
Prepare a summary of the Prison Service investigator's report and any observations and recommendations for my consideration by 30 June 2004, together with a statement of the time and costs incurred.

You should ensure that the bereaved relatives are kept informed of the progress of the investigation and that they have an opportunity to raise questions during it.

Stephen Shaw
Prison and Probation Ombudsman
11 May 2004

A2. Composition of Investigation Team

The Investigation Team comprised a Senior Investigating Officer and an assistant Investigating Officer.

B1. Investigation Process

The team began the investigation process on 14 May, under the Prisons and Probation Ombudsman's Terms of Reference. In the first instance, the Acting Governor of Durham at the time (and later the in-charge Governor) was consulted and discussions took place with the chairperson of the Independent Monitoring Board. The Chairman and Secretary of the Prison Officers Association (POA) were consulted. The wing where the incident took place was visited four times and the location where death took place (cell F4-16) was extensively and carefully examined. The Coroner's Office and the local police handling the enquiry were consulted.

All the relevant paper work relating to the prisoner, her care at Durham and the general operation of the prison, was examined. Additional reports including the last Independent Monitoring Annual report, the relevant HM Inspectors report, the last Standards Audit report, the last Quality of Inmate Life report, the last Self Audit report on self-harm and the last two reports into prisoner deaths at Durham were examined. The prisoner's next of kin was consulted at some length. The last two telephone calls that the prisoner made to her next of kin were listened to.

B2. Eight members of staff and four prisoners were interviewed.

C. Establishment Profile

1. HMP Durham is a category A Core Local and a Category B High Security prison with a Female Centre as well as two Close Supervision Centres. It was built in the early 19th century and has been undergoing regular episodes of refurbishment over a number of years. Although predominantly of traditional radial design, imposingly built of stone and occupying a cramped inner city site next to the old Law Courts, Durham is generally regarded as a reasonably good prison, presenting a relatively clean and tidy image. Its overall management struck the Investigation team as being efficient and caring. The prison appeared to be well resourced with a number of recently refurbished buildings.

2. The Certified Normal Accommodation (CNA) is 636 and the Operational Capacity is designated as 724. An average population breakdown would include 14 category A's, 35 category B's, 185 category C's, 2 category D's, 100 females, 282 un-sentenced inmates and 61 on remand. The prison's cost per inmate place is £36000 per year.

3. Female prisoners are held in F/H wing known as the Female Centre. At the time of her death, the prisoner was held in cell F4-16 which is on the top floor of four, with a window facing into the main body of the prison. The female accommodation is of Victorian structure, but it has a modern entranceway and food servery area that leads onto a well-painted and bustling interior. There are additional facilities within the wing that include a gym, a work area, three prisoner telephones, a visits complex, ablutions and washing rooms. All appeared to be in reasonable order and condition.

4. Between 19 August 2002 and 7 May 2004, there had nine deaths in custody at Durham, five of which had involved women. The last two short HM Inspectorate visits were in August 2003 and January 2004. The last visit by the Standards Audit team was in November 2002 and the last Independent Monitoring Board report was in October 2003.

5. The Independent Monitoring Board report stated, "the (Female) centre is now up to complement, with improved morale and overall effectiveness". The Standards Audit Report of November 2002 stated that, "We gained the overall impression of a well-organised operation, with highly motivated staff that perform their work effectively". The Report went on to conclude that there was a, "good level of compliance". The Suicide and Self-harm Prevention component contained within the Standards Audit Report received a 79% rating mark and was deemed to be, 'acceptable'.

6. The Investigation team visited the Female centre on four occasions and hence saw the wing operating at various stages of its daily routine. The prisoners appeared to be experiencing life within the normal decent bounds that one would expect with a cross-section of women living together, within an organised, controlled environment. The wing looked tidy, well decorated, active and busy, if a bit claustrophobic and compact. However, the cells, ablutions, food servery area, offices and washrooms that the Investigation team saw, all looked in favourable condition. Amongst the female population, there was a mixture of sentences and ages, with little movement on or off the unit. As a result of the population stability, staff got to know the prisoners fairly well. Relationships between the staff and prisoners were described to the Investigation team in an extremely favourable way by both staff and the four inmates to whom the team spoke. The management of the wing seemed good, the relationships across the whole unit seemed good, staff involvement with prisoners seemed good and the wing generally had a good atmosphere about it.

D. The prisoner's domestic and situational circumstances

1. The prisoner was born on 13 June 1958, making her just short of 46 years of age when she died. Her place of birth was Bath and her last address before coming into prison was Frome in Avon. Her last known job at the time of her arrest was Traffic Warden in Bristol. From her Inmate Medical Record (IMR), her medical situation does not appear to have been too fraught when she was remanded into custody. Apart from a knee problem that she contracted from playing rugby, she had no disabilities, there appeared to be

no serious underlying medical condition, she did not suffer from any significant psychiatric illness, she did not appear to take illegal drugs and she stated that she had no previous attempts at self-harm. This latter statement later turned out to be incorrect. She was a non-smoker with what appeared to be limited medical concerns. From her medical record, however, what could have been regarded as significant was her level of alcohol consumption out of prison. She was recorded as drinking something in the order of 6 – 8 pints of cider a day, usually in pubs. Some of the trouble in which she had become involved over the years, often appeared to be attributable to her high consumption of alcohol.

2. *Current Offence*. The offence was committed on 30 October 2002. The prisoner was arrested on 18 December 2002 and remanded into custody. She was tried and sentenced at Swansea Crown Court on 18 July and given a 10-year sentence for Arson (x2). Her sentence expiry date was 20 August 2009, but her parole eligibility date was 20 December 2007. She began her custody at Brockhill prison, moving to Eastwood Park and Styal, before being sent to Durham prison on 21 August 2003.

3. *Family*. The prisoner was the last of four siblings, born to a 44-year-old mother, with a 10-year age gap from her nearest brother. By her early 20's, she had become estranged from her mother who is still alive. There is no evidence in the prisoner's file that points to any contact with family members since she came into prison.

4. *Next of kin*. On entering prison, the prisoner listed her next of kin as a woman who lives in Bath.

5. *Employment.* From the age of 17, a work pattern out of prison was established. After a short early period in the army, the prisoner had jobs as a post woman, a computer data in-putter, a cleaner, a rubber factory worker and latterly, a traffic warden. Her education had produced a few early academic qualifications, but this seemed to have been followed by no further formal accreditation of skills. From the evidence available to the Investigation team, the prisoner was literate, articulate and intelligent.

6. *Previous Offending*. The prisoner's previous recorded offending went back to 1982. Her opening criminality was an assault on police for which she was bound over. In 1983, she was fined for criminal damage. In 1987, she was fined for public order offences and assault on police. In 1996, she was fined for battery. She then received a nine month prison sentence and a Probation Order for offences of wounding and battery she had committed in 1997 and 1998. She served four and a half months at Eastwood Park. In 2002, and again in 2003, she failed a breath test and lost her driving licence. Much of her offending appeared to have developed out of her drinking.

7. *Self-harm Monitoring.* On entering prison in December 2002, the prisoner responded in the negative to a reception interview when asked if she had ever tried to harm herself or felt that she might resort to self-harm or suicide. This in fact was contradicted by the prisoner herself later in her sentence when she

admitted to staff that she had self-harmed before coming into prison. Her prison record (F2050) from her previous sentence in 1998 at Eastwood Park, was destroyed having time elapsed. The Investigation team was unable to discover whether any self-harm gestures were recorded against the prisoner during her previous time in custody.

During her current sentence however, starting in May 2003, the prisoner became subject to six F2052SH monitoring forms as follows:-

14.5.03 – 18.5.03. HMP Styal.

A made-up ligature and suicide note was found.

13.8.03 – 28.8.03. HMP Eastwood Park.

Affixed a ligature around her neck and lost consciousness. Taken to hospital.

20.11.03 – 9.12.03. HMP Durham.

Feeling very low after death of another inmate.

8.1.04 – 30.1.04. HMP Durham.

Stated that she was going to hang herself. Had allegedly made a noose.

10.3.04 – 17.3.04. HMP Durham.

Overheard saying she would kill herself.

20.4.04 – 5.5.04. HMP Durham.

Suggestions from other prisoners that she may have had thoughts about hanging herself.

The Investigation team carefully examined the F2052SH documents in each case. It was found that the documents had not only been correctly completed, but had also been completed in a way that indicated an appropriate degree of care.

12. *The prisoner's cell*.

Cell F4 – 16 was of single occupancy on the 4th floor of the wing. The landing outside the cell was narrow but clean, bright, well aired and compact. Facing the door to the left side of cell F4-16, lived another prisoner in cell F4-15, whom the Investigation team interviewed. On the right side was a staff toilet. Observation into the cell was via a small rectangular perspex window with a similar arrangement into the toilet. The observation into the toilet however had to be made through a further opening in an inner door that acted as a limit to what area one could observe. The cell measured approximately 12' long by 7' wide and 8' high. It had a white painted ceiling and light blue walls with

a central cell light. The cell and toilet lights and the cell call bell were properly operational. In overall appearance, the cell was bright and well decorated. Facing the door was a window and in the left hand wall with a door was a further small room containing a sink and toilet. The cell contained three lockers, a bed and an open tall set of shelves. Overall, the cell appeared to be well equipped and comfortably lived in. There was evidence of no incoming letters. There was no final written note.

E. Full Description of Events.

1. *Pre-Durham Period.*

The prisoner was first arrested for her crime in December 2002, and was remanded at Brockhill and Eastwood Park prisons until her trial at Swansea Crown Court in July 2003. She moved to Durham prison in August.

2. *Matters of Significance prior to Durham.*

20 Dec 02.	Reception Health Screen questionnaire response concluded that the prisoner had never tried to harm herself.
13 May 03.	Punched wall in frustration.
13 May	Prescribed Amitriptyline medication.
14 May.	Ligature found in the prisoner's possession. Placed on 1st F2052SH.
18 May.	Taken off 1st F2052SH.
20 May	Changed medication from Amitriptyline to Zispin.
23 June	Changed medication from Zispin to Prozac.
6 July.	Recorded as becoming emotionally involved with a fellow prisoner
12 Aug.	Advised that she would be transferred to New Hall prison.
13 Aug.	Serious self-harm by strangulation in toilet area. Taken to outside hospital.
13 Aug.	Placed on 2nd F2052SH
17 Aug.	Self-inflicted lacerations to arm. Spoke to nurse about former abuse.
17 Aug.	Recorded as having said she hates herself.
21 Aug.	Transferred to Durham prison on enhanced status. Located in cell F1-2.

3. *Matters of Significance at Durham.*

22 August.	Located in enhanced cell F4-2.
28 August.	Taken off 2nd F2052SH
26 September	Given job on cleaners.
14 October.	Located in enhanced cell F4-16.
12 Nov.	Self-inflicted death of another female prisoner
14 Nov.	Probation comments record, 'thoughts of (that prisoner) bring back memories of her own self-harm in August.'

19 Nov.	Cleaned out the cell of the other prisoner who had died and allegedly discovered a piece of sheeting that appeared to have been used as a ligature.
20 Nov.	Placed on 3rd F2052SH because of that death and her own reaction to the discovery
20 Nov.	Entry made on record about a bad attitude when being advised that she could not have two duvets.
24 Nov.	Probation comments record that she felt she was of no value to anybody.
9 Dec.	Taken off 3rd F2052SH
29 Dec.	Outburst after being told to wear gloves in the wing food servery.
8 Jan 04.	Placed on 4th F2052SH having made a noose and wanting to hang herself.
9 Jan	Took herself off Prozac medication, suggesting it was doing her no good. Tearful.
27 Jan	Medical appointment for knee problem stemming from rugby injury.
29 Jan	Commenced Dialectic Behaviour Therapy course (DBT).
30 Jan	Taken off 4th F2052SH
31 Jan	Visit from partner
3 Feb	Seen by CPN nurse.
10 Feb.	Seen by CPN nurse.
13 Feb.	Refused to attend physiotherapy session for knee problem.
18 Feb.	Refused to attend physiotherapy session for knee problem.
20 Feb.	Seen by CPN nurse.
10 March.	Placed on 5th F2052SH. Overheard saying she would hang herself.
17 March	Taken off 5th F2052SH
24 March	Scored herself 3 out of 5 on feelings of suicide, on DBT course.
7 April	Did not attend her DBT session.
11 April	Scored herself 3 out of 5 on feelings of suicide on DBT course.
14 April.	Refused to attend physiotherapy session for knee problem.
20 April	Placed on 6th F2052SH. Made a noose and had thoughts of wanting to hang herself
23 April	Attended her DBT session.
27 April	Altercation with one of the tutors on DBT session.
30 April	Attended her DBT session.

4. *Events in last week of life.*

3 May	Telephone call to partner
4 May.	Spent £17.16 in prison canteen shop.
4 May.	Involved in cup of coffee throwing incident.
4 May.	Temporarily removed from servery job. Probable start of food refusal.
4 May	Requested a listener in the evening, but then declined one when she discovered it would not be her friend
5 May.	Taken off F2052SH monitoring process.
6 May.	Reluctantly spoke with DBT tutor, about not turning up for the last session.

6 May.	Telephone call to partner
7 May	Failed to attend DBT course.

5. *Temper Outburst.*

According to various records, the last week of the prisoner's life was quite a mixture of events. Despite being an enhanced inmate as well as in a favoured job on wing servery/cleaners, on 4 May, the prisoner took umbrage at a member of staff's instruction that she return to her cell for a meal time roll check. She threw a cup of coffee onto the landing in anger and displayed a temper that questioned her suitability to continue working on the servery. In the Investigation team's view, concern was rightly expressed about her temperament, and she was removed from the servery job for a 'cooling off period.' The prisoner subsequently stated to other prisoners as well as in a telephone call on 6 May to her partner, that she had been 'sacked'. It is probable that in reality, she appreciated that her removal was only temporary - it had been explained to her carefully. The Investigation team found sufficient evidence that she was deeply upset by the temporary loss of her servery job.

6. *Cognitive Skills Training.*

The DBT sessions that the prisoner had been intermittently attending since late January 2004, appeared to be an encouraging challenge to the way she saw the world, according to the higher psychologist who worked with her. The sessions began to tap areas of her character that had remained unchallenged for years. The prisoner was disturbed by the penetration of the course at times, but she seemed stimulated by the odd insight she had of herself. She failed to attend the session that was planned for the 7 May.

7. *Medication.*

Having consistently taken medication during her sentence until the beginning of January 2004, somewhat to the concern of the nurse who was dealing with her, the prisoner took herself off it. There was an expectation that her instant termination of medication would bring about some withdrawal problems. In fact, this had not happened, somewhat surprisingly according to the medical staff. On 7 August, the prisoner approached one of the nurses and asked to go back on Prozac, as a response to some other prisoners who had apparently suggested to her that she had become moody, in contrast to the period when she had been on medication.

8. *Food Refusal.*

The record shows that there was one previous occasion in her sentence when the prisoner did not take her food for a day. Other than this, all the evidence seemed to suggest that she was a good eater. By listening to a recorded 6 May telephone call that the prisoner made to her partner, it emerged after her death that she had not been taking food for some days. The prisoner told her partner that she had not taken food for 3 days, 'to make a stance'. It would appear that the start of food refusal coincided with the point when she threw

the mug of coffee onto the landing and lost her job on the servery as a consequence. If she intended to ‘make a stance’ by refusing food as she said, it seemed to have been a stance about which nobody knew. The Investigation team understand that nobody except the prisoner’s partner learned of this until after her death.

9. *F2052 Monitoring.*

The 6th F2052SH that had been opened on 20 April, was closed on 5 May. Sixteen days after the process was begun, a review panel of five staff including the unit principal officer, two wing officers, a psychologist and a probation officer had all agreed that despite the previous day’s cup of coffee throwing incident, the prisoner appeared to no longer need to be monitored. She was present at the review. She had shown her usual rejection of the F2052SH monitoring process. Many staff and two prisoners told the Investigation team that she never liked being on the F2052SH system and, despite the obvious self-harm risks of her behaviour, she always suggested that she was at no risk.

10. *Immediate Events Leading to Death.*

From interviews with staff and prisoners, the Investigation team as far as possible are able to piece together the following sequence of events on the morning of 8 May. Unlocking of the Unit seemed to have run as normal. The prisoner was seen by her friend at shortly before 9am when a conversation ensued about whether the prisoner wanted to help get the food trolley. The prisoner declined, whereupon her friend left to go about her duties. In the mid part of the morning, a member of staff told the prisoner that she was to do some mopping on the 4’s landing. This provoked a bit of hostility from the prisoner, and when her friend turned up, some of this hostility turned on her. The prisoner’s friend then left the area to go down to the servery. At about 11am, her friend returned and had a coffee with her and the disagreement was patched up with an amicable talk, an apology from the prisoner and a comforting hug. A member of staff recalled seeing the prisoner mopping the landing mid morning and noted nothing untoward in her demeanour. At about 11:10 am, her friend asked the prisoner if she was going to have her lunch later. The prisoner declined. An agreement was then made between the two of them that they would cook some pancakes in the afternoon after unlock. It would appear that her friend, let alone anybody else, had no idea that the prisoner was allegedly not taking her food.

At around12:05pm, a member of staff recalls locking the prisoner in her cell and a cheerful brief exchange took place with the parting words from her that she would see the officer in the afternoon. The last the officer saw of her was lying on her bed listening to music. The prisoner’s friend came back up to the 4’s landing around 12:10pm and remembered talking to the prisoner through the observation flap. The prisoner had been lying on her bed listening to music. She asked her friend to promise that she would come back at unlock and the two of them would cook some food. With nothing extraordinary about

the prisoner to worry her friend, she left her door and went back to her own cell to be locked up for lunch.

At approximately 1:30pm, cell F4-16, along with other cells, was unlocked in the normal way by a staff member. The prisoner's friend went straight to the prisoner's cell and discovered her hanging behind the lavatory door of her cell. She went onto the landing and called for help. The prisoner's next-door cellmate rang the alarm bell and the wing senior officer (SO) got to the cell at about 1:34pm. A radio call for assistance was made by the SO. With the assistance of another officer, the SO remembers taking the ligature off the door handle and then removing the noose quite easily from around the prisoner's body. At one point, it would appear that five officers and one SO were helping in one way or another to revive the prisoner in her cell. It was noted by one member of staff that she exhibited dark lips. In order to create more room, some furniture was removed from the cell whilst mouth-to-mouth and heart massage were applied. At different points, searches were made for a pulse both in the neck and on the wrist. One of the prison nurses arrived in the cell at around 1:40pm and continued with mouth-to-mouth. No prison heart-start equipment or oxygen was used until the ambulance arrived. At 1:51pm, the ambulance staff arrived at the cell and carried out life saving procedures. At 2:10pm, the ambulance crew left the prison. At 2:20pm, the prison doctor certified death. At 5:48pm, the undertakers left the prison with the prisoner's body.

The Investigation team have not been able to see the autopsy report.

F. Level of Compliance with Prison Service Standards.

1. The Investigation team examined the **F2052SH monitoring process** in careful detail, particularly through the six forms that had been opened on the prisoner's behalf. The documentation was opened and closed for the right reasons and was completed correctly. The entries by and large seemed also to suggest a degree of genuine care when staff added their comments. Some of the entries on the daily supervision notes suffered from an element of being a bit mechanical, but the reviews were adequately carried out with the prisoner present and within the formal instructions laid down by the Prison Service. The F2052SH monitoring process could not be criticised.

2. Five sets of minutes from the **Suicide Prevention Meetings** were examined. There was one occasion when the meetings were more than three months apart (August 2003 and December 2003). The make-up of the membership was comprehensive in each case, but could usefully have included some representation from the external agencies other than the Samaritans. Missing from the agenda was some feedback from the Anti Bullying Committee. There also appeared to be no indication that the committee carried out a quality check of any F2052SH's that had been closed since the previous meeting. Apart from the criticism above, the general conduct and outcome of the meetings appeared to have been within Prison Service guidelines. (Her Majesty's Chief Inspector of Prisons had noted that

there were no standing agenda items for women and little discussion about issues specific to women.)
3. The **Self Audit of Standards Baselines** specifically related to suicide and self-harm prevention was examined. There were no non-compliant baselines that needed addressing and all the procedures had been completed correctly.

4. The **Suicide Prevention Policy document** was examined. This document had been revised in July 2003 and hence was current and up to date. (HMCIP had been critical that the document did not consider sufficiently the specific needs of women.)

5. The final report on the combined **Standards and Security Audit** that was available related to a visit by the Audit team in November 2002. The Suicide and Self Harm, as well as Safer Establishments baselines were looked at. The former received a 79% score with an “Acceptable” rating and the latter received an 87% score with a “Good” rating. Both sets of scores suggest a prison that is operating to an acceptable level in these two key areas.

6. Five sets of Minutes from the **Suicide Awareness Support Group** meeting were examined going back to March 2003. The last meeting of this group was 12 February 2004. The attendance at the meeting by both senior staff, outside people and prisoners appeared good, with few apologies other than for the meetings in June and March 2003, where membership was smaller than it later became. The minutes reflected what appeared to be constructive meetings with adequate matters recorded and action points for specific staff to follow up. There were no specific references to women.

7. The Investigation examined the dedicated **Listeners Suite** on the 4th landing of the Female Centre. This facility was the cornerstone of the safer custody system and provided a venue for distressed prisoners to seek sanctuary within a pleasant environment where they could talk confidentially about their problems with a fellow Samaritan trained prisoner. The facility was in good order and, according to the accounts given to the Investigation team, was appropriately used. The Investigation team was told that ‘listening’ could take place in prisoners’ cells on occasions, but the ideal situation would always be for the Listener and prisoner to use the official Listener suite facility. The blurring between ‘formal’ use of the Listener suite and more ‘informal’ use of other venues, gave rise to a lack of clarity as to the quantity of prisoners needing self-harm support. A record was kept of how often the Listeners suite was used, but this threw little light on the scope of self-harm problems, because other unrecorded venues were being used. The situation suffered from the preferred use of the more ‘formal’ Listener suite, as against the ‘informal’ use of other venues when the practicalities may have called for an immediate less contrived response.

8. A small department called the **Safer Custody Unit** had been set up at Durham in February 2004, with the intention of monitoring prisoners who were at risk of self-harm. This Unit consisted of half a Principal Officer, a full-time Senior Officer and two part-time officers. As part of the investigation process, the Investigation team made contact with this group and became acquainted

with the scope of their work. The Unit made contact with individual inmates as well as working with wing staff and they were a noticeable presence particularly on the Female Centre. This Unit appeared to be a positive and pro-active approach to a problem that Durham saw as important.

9. Local **Contingency Plans** were appropriately followed. On discovery of the incident, staff reacted in accordance with laid down procedures and actions developed along prescribed lines. The Investigation team had the Care Team described to them by various staff in a way that demonstrated the psychological needs of the staff were well attended to. Staff were able to get across their concerns and suggestions at the debriefs in a way that appeared to have helped the situation. The Samaritans manifestly offered a good service to the inmates and the Female Centre Listener scheme, with a team of nine Listeners, was well respected and used appropriately. According to the Incident log, the non-appearance of a senior manager in the immediate aftermath of the incident possibly conveyed a lack of concern by senior managers. The incident occurred in the middle part of the day on a weekend, and the log failed to record any senior manager coming into the prison and going to the Female Centre, despite the fact that there had been something as serious as a prisoner's death.

G. Findings and Conclusions.

1.The ligature.

The ligature was made of two drawstrings tied together; one white and one dark blue. It has not been established exactly from where these drawstrings came, but it may have been from the prisoner's nightwear shorts. They were fashioned into a set of small loops on one end that were capable of fitting over the knob of a door handle. The other end was made into a noose with a knot that allowed the ligature to tighten when pressure was applied. The knot that allowed the string to tighten was extremely fragile. The position of the ligature point may have been deliberately chosen by the prisoner to ensure that she could not be observed by staff.

In an interview transcript that the Investigation team studied, relating to the death of a prisoner at Durham in November 2003, the prisoner stated in a recorded interview dated 19 November 2003, that she was adversely affected by an incident some days after the event. This involved the prisoner allegedly discovering the ligature that the other prisoner had used to end her life. The prisoner described how there was blood on the ligature and how the discovery had, 'stressed and unnerved' her. She described how it was not helpful for her to have discovered such a thing, 'given her past'. The Investigation team formed a view that this incident was likely to have had an adverse impact of some sort on the prisoner's propensity for self-harm. Because of this experience, the prisoner was placed on an F2052SH on 20 November 2003. At that point, it was recorded by a member of staff on the F2052SH form, that the prisoner said she was, 'jealous (of the other prisoner) because she was in a better place.'

2. *Staff.*

Every member of staff interviewed described the positive and helpful approach displayed by the Female Centre staff. The prisoners we spoke to said the same thing. Quite unsolicited, the four prisoners to whom the Investigation team spoke went out of their way to confirm an extremely caring approach by all the staff. One of these four prisoners was not known for her full co-operation with the regime, but even this prisoner stated that the staff on the Unit were particularly good with their charges. It was the experience of the Investigation team that the staff did seem to adopt a very pro-active and positive approach to their prisoners that conveyed to the team a noticeably co-operative and friendly environment.

Despite the death of the prisoner, the Investigation team found the staff and the prisoners to be upbeat and cheerful. The general atmosphere on the Unit appeared to be good at the time of the investigation. The staff complement of the Unit at the time of the Investigation, showed them to be at full strength. The layers of staff from the managers, to the landing officers, to the safer custody staff, to the medical staff, to the probation staff and the psychology staff all seemed to operate as a pretty well trained and effective team, and no criticism could be levelled at this aspect of the Female Centre operation.

3. *F2052SH Self Harm Monitoring Process.*

The implementation of the self-harm monitoring process has been recorded earlier in the report. By definition, the perception of the prisoner's self-harm risk was relatively high, as evidenced by the fact that there were a total of six F2052SH's opened and closed on her in a 12-month period spanning 84 days in total.

4. F2052SH Review Process.

Because of reports that the prisoner had feelings of self-harm and had, 'handed out' a ligature some days previously, a F2052SH process was started on 20 April 2004. It was ended 16 days later on 5 May 2004 following a review process that deemed the prisoner's risk of self-harm to have been minimised. This was three days before her life ended.

A careful examination of the F2052SH document shows that it was opened correctly by one of the Female Centre SO's and a clear written explanation of the reasons was contained on page one. Despite what appeared to be genuine concerns for her, the prisoner was recorded as expressing her unhappiness at becoming part of the process. A doctor made an appropriate entry from the medical perspective on 20 April. The required 72-hour review was carried out and the usual protest from the prisoner was recorded. A 16-day run of appropriate entries was made on the supervision pages for each day from 20 April through to 5 May. The eight to ten timed entries each day document a relatively positive picture, other than the entry on 4 May that refers to the cup-throwing incident. This incident interrupted a fairly positive flow of comments that at some points referred to the prisoner as being happy

and laughing. The planned Review for 5 May duly took place under the chairmanship of a Principal Officer and four other staff. The prisoner represented her case and stated that she was over the ‘hitch’ that necessitated the F2052SH in the first place. Reference was made to the cup-throwing incident the previous day, but the view of the Review panel was that all appeared well. The panel did not know that the prisoner might have been into her second day of food refusal and the panel also did not fully appreciate the anger she felt about the loss of her servery job. These matters only came to light in a telephone conversation the prisoner had with her partner a few days before she died, the transcription of which only became available during the investigation. For the same reason, the only picture that was available to the panel at the time of the review was the word of the prisoner herself, the entries from the F2052SH document and their own observations. It later became known that the 5 May Review coincided with the prisoner not being happy about her loss of the servery job. She happened also to be concerned about her own demeanour such that she wanted to return onto some medication. She had started her food refusal ‘stance’. She had lost her temper on the previous day over the cup-throwing incident and she was intending to withdraw from the DBT course. Had the review panel appreciated all these factors, it would seem reasonable to suppose that they may have viewed their decision differently. At one of the interviews with the prisoner’s friend the Investigation team were told that even on the morning of her death, the prisoner appeared to her friend to be alright. Despite the fact that the review panel’s decision to remove the prisoner from F2052SH monitoring subsequently proved to be premature, it was nonetheless hard for the Investigation team to suggest that the review panel made a mistake at the time, based on what they could reasonably have been expected to know.

5. *Cup Throwing Incident and Loss of Job on the Wing Food Servery*.

From everything that the Investigation team discovered, the incident in the early part of the prisoner’s last week alive described above, where she threw a cup of coffee and subsequently lost her job on the servery, undoubtedly upset her in a major way. To some members of staff, the prisoner gave the impression that after the first 24 hours she had got over it. It had been explained to her that the loss of this job was only temporary for a ‘cooling off period’, and although the Investigation team are uncertain that she understood this, it did not prevent her articulating the fact that she had been ‘sacked’ and her recorded telephone conversation with her partner on 6 May demonstrated that she was very sore about the incident, which affected her badly.

It is the view of the Investigation team, that the prisoner’s removal from the servery job after the coffee throwing incident was an appropriate course of action.

6. Medication.

According to the prisoner’s medical records, she was prescribed anti-depressant medication between May 2003 and January 2004. She began her

medication in May 2003 with Amitriptyline, replaced fairly quickly by Zispin, to be replaced by Prozac in late June. In January 2004, she took herself off Prozac, suggesting that she felt it was doing her no good. For a knee complaint, she was given Ibuprofen from April 2003 onwards, which she seemed to have taken continuously but intermittently right up to her death. After she died, the Investigation team came across 40 Ibuprofen tablets in her cell.

Prior to coming into prison, the prisoner appears not to have been on any kind of medication. The outburst in May 2003, whilst on remand, when she punched the wall, seemed to have precipitated her resort to anti depressants. She used anti depressant medication for seven months and then decided herself to stop. The belief in the Durham medical centre was that she would probably suffer some kind of withdrawal symptoms by taking herself off medication, but much to staff's surprise, she appeared not to have done so. After a three month gap, and just two days before her death, the prisoner decided that she would like to return to Prozac as a response to her peers suggesting that she was moody and was better when she was on medication. This was despite a statement she made to her partner in a telephone conversation on 6 May that she would no go back on pills. The prescription was not dispensed before her death. After her death, the independent medical assessment by the Primary Care Trust stated that the prisoner's health care was 'relevant' throughout her period in prison.

7. Listeners and Issues of Confidentiality.

Both staff and prisoners on the Female Centre raised the issue of Listener confidentiality as an area of concern. The point was made to the Investigation team, that the close knit nature of the Centre meant that, a) Listeners were very often friends of the people to whom they were listening, which could create conflicts and, b) Listeners sometimes held sessions with prisoners where threats of self injury emerged, but questions of confidentiality prevented those warnings being passed on to staff. Two listeners, who happened to be good friends of the prisoner, were privy on occasions to her threats of self-harm, where they felt difficulty in passing that on to staff, because of confidentiality.

(NB See PPO comments on page 7 above)

8. Efforts to revive the prisoner.

We have described above the events after the prisoner was found with a ligature round her neck, as best the Investigation team could piece events together. An SO with five other officers gave immediate attention, later accompanied by a nurse from the Health Care Centre. The ligature was removed, a pulse was searched for, mouth to mouth and heart massage were applied until the Ambulance Service took over.

Every effort appeared to have been made to try to rescue the prisoner. For whatever reason, the heart start equipment and the oxygen from the Health

Care Centre were not brought to the cell. It struck the Investigation team that this equipment ought to be a standard item brought to the scene when a prisoner threatened their life.

9. *Institutional Factors*.

The Investigation team felt certain that the explanation for the prisoner's actions was unlikely to have rested on one single factor. It struck the Investigation team that there was an interwoven web of intricate ingredients involved. Added to this mix was the undoubted impact of five previous women in the Female Centre over the previous two years having taken their lives. It was the view of the Investigation team that this was likely to have been an ingredient of some consequence in this prisoner's death.

The Investigation team felt ill-equipped to understand fully the dynamic created by so many women ending their lives within one living area over a relatively short space of time. The dynamic of a mixed group of women living together in an enclosed environment, some with extremely complex problems and others with a propensity for self harm where six self inflicted deaths had taken place in the last two years, was outside the level of understanding that the Investigators could bring to an inquiry like this. It was already recorded in this report that during the course of the investigation, the Prisons Board had decided to close the Female Centre.

The Investigation team felt unable to level any criticism of the systems and processes at Durham prison that were in place to prevent prisoner deaths. Neither could the team feel justified in levelling criticism at the Female Centre staff who carried out their work with care and compassion.