Circumstances surrounding the death of a woman in HMP & YOI Low Newton in July 2004

Report by the Prisons and Probation Ombudsman
for England and Wales

January 2006

This is a report into the circumstances surrounding the death of a woman who died in HMP & YOI Low Newton on 28 July 2004. She was just 22 years of age. I offer my sincere condolences to her family on their sad loss.

Under transitional arrangements agreed with the Prison Service at the time, a Senior Investigating Officer (SIO) was appointed by the service to conduct the investigation. The SIO worked to me for the duration of the investigation and submitted a draft report that I subsequently reviewed and amended as necessary. This final report represents my independent examination of the circumstances leading to this woman's death.

The SIO who conducted the investigation was the Governor of HMP Acklington. He was assisted by a colleague. There was also an investigation liaison officer from this office appointed. The team met the woman's mother and her partner at her mother's home at the outset of the investigation. I am most grateful to them for inviting the investigators into their home at such a difficult time, and for sharing a picture of their daughter and as a mother herself.

My investigation team met with the woman's mother and sister again when I had completed my draft report. Following this meeting some additional enquiries were undertaken and the report amended accordingly.

A clinical review into the care and treatment by the Prison Service was commissioned from Durham and Chester-le-Street Primary Care Trust (PCT). The review was undertaken by an accredited appraiser of General Medical Practitioners. A further review into the detoxification procedures at Low Newton was commisioned from and undertaken by Prison Health.

The investigation team was offered every assistance by staff and prisoners at Low Newton.

This version of my report, published on my website, has been amended to remove the name of the deceased and any names of staff or prisoners who were involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2006**

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Low Newton

Low Newton is a closed prison for women. It holds both young prisoners (under the age of 21) and unconvicted and sentenced adults. It has a Certified Normal Accommodation (CNA, maximum uncrowded capacity) of 343 and an Operational Capacity (maximum crowded capacity) of 396. On 28 July 2004, the population was 305.

Low Newton has a purpose built induction unit which opened in July 2003. It caters for up to 40 prisoners mostly in single cells. The standard of the cells is recognised as very high and all cells have their own toilet and shower recess, which is not visible from the observation hatches in the cell doors. A comprehensive rolling induction programme is in operation. The programme lasts for one week. Prisoners begin the programme on whichever day of the week they arrive and stay on the induction unit to complete it before moving to one of the other wings.

Low Newton has a full-time healthcare centre including in-patient facilities and safe cells for women at risk of self-harm. It was a pilot prison for the Prison Service's Assessment Care in Custody and Teamwork (ACCT) process which is replacing the F2052SH system for monitoring those prisoners most at risk of suicide and self-harm.

A recent Prison Service audit rated standards and security at Low Newton as good. The most recent report from HM Chief Inspector of Prisons noted excellent staff/prisoner relationships, and commented very favourably on the work done by Low Newton to help women settle back into the community on release.

2. The events leading up to the death

(i) Monday 26 July 2004

On 26 July 2004, the woman was sentenced to 27 months imprisonment at York Crown Court. The Prisoner Escort Record (PER) form shows she arrived at Low Newton at 5.00pm. The form indicates that the woman was judged to present no known medical, self-harm or security risk. The form notes that she had problems with drugs.

The woman spent about two and a half hours in Reception at Low Newton before being transferred to the Induction wing (I wing). A cell sharing risk assessment (CSRA) form completed in Reception shows that she said she was currently dependent on drugs and did not have any concerns about sharing a cell. She was recorded as presenting a low risk. A nurse completed the healthcare section of the CSRA and also undertook the woman's first reception health screen. The woman told the nurse that she had no health concerns. The woman said she did not expect to be sent to prison but indicated that she did not feel like hurting herself and did not feel suicidal. At interview, the nurse said that the woman did not seem depressed at all and had answered all the questions put to her. She said the woman did not raise any other concerns with her on that first evening.

The woman was also given a CARAT's (Counselling, Assessment, Referral, Advice and Throughcare) substance misuse assessment in Reception. She acknowledged that she had a drug problem and indicated that she would like to see a drugs worker while in prison.

At 7.00pm, the woman called her mother from Reception. She told her mother that there was someone she knew in the prison. She told her mother she was worried this other woman was going to "start". At the end of the call, the woman told her mother that she could visit within the next seven days. She called back briefly a minute later and left a message for her mother saying she would write and asking her to bring some jeans and a jumper when she visited.

An officer said he was on I wing at 7.20pm on 26 July when he received a telephone call from Reception staff telling him that the woman was "in an agitated state, probably because of her sentence length". He said he made an entry in the wing observation book.

Another officer said she first met the woman at about 7.30pm when she was brought over to I wing from Reception by a reception officer. She said the woman was tearful and seemed frightened. She said the woman told her that there was a problem with another prisoner, and she was worried about what this prisoner would do when she saw her. She said that she spent about ten minutes reassuring the woman that staff would not allow her to be intimidated by any other prisoner and telling her about the Listener scheme (Listeners are prisoners trained by the Samaritans). She said she told the woman that prison was not like *Bad Girls* or other television programmes, and the woman told her that she knew other women in Low Newton and was not worried about prison as a whole, simply about this one prisoner in particular.

Two officers showed the woman to her cell and showed her how to use the cell bell and the television. She said the woman went to get some hot water and seemed "ok". She said she told the woman that she and the other officer would go and see this other prisoner and then come back to see her.

The two officers asked the prisoner whether she would cause any problems on the wing if she saw the woman The officer said the prisoner appeared agitated, and initially said that there would be a problem, but then seemed to calm down a bit and told them that she would ignore the woman. The officer said that at this stage she did not know what the issue was between the woman and the other prisoner. She said they then returned to the woman's cell and told her that the prisoner she was concerned about had said that she would ignore her. The officer said that the woman appeared "quite pleased" by this news, but then became agitated again when she started talking about the history between them. The two officers spent a few more minutes trying to calm the woman down and when they left she "seemed fine".

The officer said he was in the wing office when the woman arrived on I wing from Reception. He said the woman said "Oh she's seen me" and he turned round and saw a prisoner on the landing. He said he asked the woman if there was a problem and she started crying. The officer said he left the woman and his female colleague in the wing office and went to lock up all of the other prisoners. He and his colleague then took the woman to her cell and tried to reassure her that she would be all right. He said they then went to speak to the other prisoner. She was also agitated but eventually agreed to keep out of the woman's way. The officer said he returned to the woman's cell with his colleague and the woman told them why she was worried about this other prisoner. The officer said he tried to reassure the woman and told her that she would remain in her cell in the morning as part of the usual induction procedure and staff would try to find a way of dealing with the situation. He said the woman seemed to be quite happy with this and when he checked on her again later she was watching television. He said that he told night staff to listen out for any shouting during the night.

The I wing observation book shows two entries relating to the woman on 26 July. The two entries are made by the two officers referred to above.

> "This prisoner was tearful in Reception and does not know what is happening. Staff to monitor".

The second entry reads:

> "It now transpires that [this woman] is afraid of [another prisoner] in I-5 due to a long running dispute. Both have been spoken to individually and both have assured staff they will keep out of each others way tomorrow and there will be no trouble".

(ii) Tuesday 27 July

The following day one of the officers was on an early shift and night staff reported to him that there had been no shouting in the night. He visited the woman in her cell at about 7.50am. Because of the events of the previous evening, he said he thought the woman should make a written statement. He said she completed a statement and he gave it to a Senior Officer.   The officer said that the SO decided that, because the prisoner was on her last day of induction, the woman should be kept in her cell when the prisoner was on the wing. He said that the woman would normally have spent most of that first day in her cell in any case.

The woman had her breakfast taken to her in her cell. The officer said he noticed that the woman and other prisoner were both due to visit the healthcare centre at 9.00am. He rang

healthcare and told them that the two women were to be kept separate. He arranged that the prisoner should be taken to the ‘bottom’ healthcare centre and he escorted the woman to the ‘top’ healthcare centre. He said he did not see any prisoners at the woman’s door on Tuesday morning and was not aware of any contact between the woman and the other prisoner.

The SO said that he interviewed the woman on Tuesday morning as part of her induction programme. He said she seemed “perfectly all right” and gave him no cause for concern. He said he was aware that the woman had concerns about another prisoner and he had seen a written statement from her. He said he decided to keep the woman in her cell until Wednesday 28 July when the other prisoner would be moved to another wing. He said that the woman appeared to be content with this plan and, had she raised any objections, he would have considered making different arrangements.

A substitute Anglican Chaplain, said that she saw the woman at about 11.30am. She said she tried to see the woman earlier but she had been in the healthcare centre during the morning. The chaplain said that the woman was “very quiet, very subdued”. She said she talked to her about family support and the woman told her that she had family in York who would visit her. She said she had two children and became quite tearful when speaking about them. The Chaplain said the woman was aware of her likely release date, and told her that she knew some of the other prisoners in Low Newton. The Chaplain said she asked the woman whether she had ever self-harmed or had any thoughts of suicide. The woman told her that the thought of her family and her children would stop her from doing either. The Chaplain said the woman was planning towards her release date and thinking of seeing her children.

The Chaplain said that she spoke to wing staff afterwards and told them that the woman was quiet and tearful. She said staff told her that they knew there were problems and that she was being kept in her cell as a precaution. She said that on a prisoner’s first day of induction they were usually locked in their cells for most of the day. On Tuesdays, prisoners were locked in their cells during lunch because they had a packed lunch instead of going over to the communal dining room.

The Duty Governor, made her regular check of the induction wing at 11.40am. She noted in the wing observation book that the prisoner was due to be moved to another wing the next day and said staff should continue to monitor the situation closely.

An officer familiar to the woman said she talked to her briefly at about 3.00pm. She said the woman had seen a probation officer. She asked her how she was and took her back to her cell.

Another officer said he took the woman for her evening meal at about 5.15pm. He said she appeared calm and relaxed and was watching television. He asked her if she was okay and she replied that she was fine and thanked him for bringing her tea.

The officer familiar with the woman went back to see her in her cell some time after 5.00pm when the other prisoners had left the wing to go to the dining room. She said the woman was eating her evening meal. She asked her how she was and the woman said she had not had any problem with the prisoner she was concerned about. She told the officer that the prisoner had not been to her door and she appeared pleased with how things were going. The officer said that she gave the woman some more information about visits and let her out of her cell to use the phone, empty her bin and get some hot

water. She said that the woman made a phone call to someone who was not in and asked if she could try again later. The officer told her that the phones were turned off at 7.00pm and the woman said she would try again the next morning. The officer said she reassured the woman that at 10.00am the next morning the prisoner she was concerned about would be moved to another wing and that she would start her induction programme. The officer said the woman seemed "absolutely fine". She said they shared a joke that at least the woman would not have to share her tobacco while she was in her cell. She said this was at about 5.25pm. The officer said she saw the woman for the last time at about 7.10pm when she asked her if she wanted some hot water.

The woman wrote a letter to her mother at some point on 27 July. She said she could not believe the length of her sentence but thought that she would only serve eight months in prison if she got a "tag" (Home Detention Curfew). She said she was on the induction wing for a week and was being given "DF's" (dihydrocodeine – for patients withdrawing from drug use) which "isn't much" but would help. In her letter she said that the prisoner had shouted to her and called her a "nonce". She said she had told staff about this. She asked her mother to send her love to her boyfriend and make sure he had the prison's address so he could write to her. She asked her mother to send her some money "before next week" so she could do her canteen sheet. She also asked her mother to bring her daughter with her if she was going to visit in the next seven days. She said that she hoped to see her mother "soon".

(iii) Wednesday 28 July

The officer on duty during the night of 27 July until early morning on 28 July, said that nothing unusual occurred during the night. He said that he last saw the woman at about 6.00am when she was asleep in her bed.

Another officer said he started unlocking the cells on I wing at about 8.05am. He said he was told at the morning briefing that he would need to take the woman's breakfast to her in her cell. When he came to her cell during unlock, he looked through the observation hatch and saw her asleep on her bed. He said he unlocked the remaining cells on the wing and went to the association room to organise distribution of the breakfast packs for the other women on the wing. He returned to the woman's cell at approximately 8.50am with her breakfast. He said he opened the hatch and shouted her name. He said he could see the woman was not in her bed and the door to her bathroom was open. He said he shouted her name again and again heard no reply. He said he opened the cell door, entered the bathroom and saw the woman hanging from "the bar above the shower/screen door" in the shower.

The officer said he shouted to the prisoners in the cell opposite to get other members of staff (he was not carrying a radio) and then lifted the woman up to try to take the pressure from the ligature off her neck. He said he was joined immediately by another prisoner. He said he told the prisoner to help him lift the woman. This prisoner supported the woman, he removed the ligature from around her neck. He said he moved the woman into the main cell and began mouth to mouth resuscitation while the prisoner helping him did chest compressions. He said that the woman looked grey and her eyes were glazed and open. He said he could detect no sign of life. The officer remembered being handed a mouth guard and then a Healthcare Officer taking over from him. He said that, at that point, he left the cell. The officer said he was on leave for the three weeks leading up to 28 July and had not met the woman before. He said that staff had complained about the ligature point in the showers used by the woman since the induction wing opened a year previously.

CCTV footage for the morning of 28 July shows a prisoner go to the woman's cell between 8.09am (when the officer looked through the woman's hatch) and 8.50am (when the officer can be seen knocking on the woman's door). The prisoner is seen to kick the door and appears to say something before moving away. The prisoner is clearly identifiable.

The prisoner that assisted the officer with resuscitation said she was walking past the woman's cell and saw the officer waiting outside with her breakfast. She said he called out to the woman but did not get an answer. She said they exchanged looks and he opened the cell door. The prisoner said she followed him into the cell and they saw the woman in the shower room. She said the officer shouted to other prisoners that there was an emergency and a fellow prisoner ran to fetch other staff. The prisoner said that the woman had used a slim brown belt as a ligature and wrapped it around part of the shower. She said that she thought the woman was already dead when she first saw her. She said that she and the officer supported the woman with some difficulty and the officer managed to remove the belt from around her neck. They then moved the woman on to the floor next to her bed and began CPR (cardio-pulmonary resuscitation). The prisoner said that before she came to prison she worked as a nurse support worker and was a trained first aider. She said she continued to try to resuscitate the woman until she was relieved by an officer who told her he was a paramedic.

Another officer said she was in the office with her colleague when he left to give the woman her breakfast. Shortly after he left, she said she looked at the monitor and could see a lot of activity in the corridor. She said she told her colleague that she was going to find out what was going on. As she left the office she said she saw a prisoner coming towards her shouting "emergency". The officer said she pressed the alarm bell on the wall next to her and ran towards the woman's cell. She entered the cell and found her colleague and a prisoner supporting the woman and trying to remove the ligature from the shower cubicle. She said they then managed to lay the woman on the floor and started CPR. Another officer entered the cell and told the prisoner to leave. She said the prisoner replied that she was a trained nurse and the officer then told her to carry on. Several other staff arrived soon after and the prisoner was taken back to her cell. The prisoner very upset so an officer stayed with her for a little while.

An officer said she followed her colleague when they were told of the emergency situation. When she realised what had happened she left the cell to help clear the landing and take the other prisoners back to their cells.

An officer said a prisoner came towards him and his colleagues shouting "emergency" and the alarm bell was pressed. He said it was obvious where the emergency was because there were a large number of prisoners congregating outside a particular cell. When they got to the woman's cell, he saw an officer laying the woman on the floor and a prisoner helping him give her CPR. He said he could not understand why the prisoner was there and asked her to leave to make way for staff. He said the prisoner or his colleague told him that she was a trained first aider so he told her to carry on. The Senior Officer arrived a few seconds later and he told him to shout for healthcare staff. He said he thought that the healthcare officer and nursing staff arrived very quickly afterwards.

The Senior Officer said that he was in Reception when he heard the alarm bell. He said he went directly to the induction wing where he found an officer and prisoner performing CPR on the woman. He said the woman appeared lifeless. He said he told the prisoner that he would take over from her but let her carry on when she told him she was a trained

nurse. The SO said that, shortly afterwards, the healthcare officer and nursing staff arrived with the hospital bag and resuscitation equipment. The healthcare officer and a nurse took over from the officer and prisoner. The SO said he opened the hospital bag and passed equipment to the healthcare officer when he asked for it.

The healthcare said he was outside C and D wing office when he heard the alarm bell. He said the time was approximately 8.55am. He had a radio with him and heard that the alarm was on I wing. As a trained instructor in Control and Restraint techniques (C&R), he went immediately to the scene, which took him about 30 seconds as the gates were open. The healthcare officer said it was only when he arrived at the woman's cell that he realised that it was a medical emergency. He is a first aid instructor and a qualified ambulance technician in the Red Cross. He said he saw an officer applying mouth to mouth rescue breath and a prisoner applying chest compressions. He said he asked somebody to bring the resuscitation kit and took over from the prisoner telling her that he was a trained ambulance technician. He said the time was then 8.56am. He said there were two resuscitation kits, a cut down version held in the wing office and another one in the healthcare centre. He said he initially used the kit from the wing office. He said the Nurse Manager, took over chest compressions and he inserted an oral-phalangeal airway into the woman. He also used a 'bag and mask' to administer oxygen to her from a cylinder. He said this method of resuscitation was continued until the ambulance paramedics arrived at approximately 9.10am.

The healthcare officer said that when he first saw the woman she was very pale and cyanosed (blue lips and extremities indicating a lack of oxygen). He said her pupils were fixed and dilated and she made no response to any physical stimulus. There was no sign of a pulse. He said he asked the doctor to confirm that there was no pulse, which she did. He said the paramedics arrived and he continued to give the woman oxygen while the paramedics assembled their equipment. The paramedics then applied a defibrillator to see if there was any response from the woman's heart. He said death was pronounced 9.17am.

A nurse said she was radio call sign Hotel 1 on 28 July (the person designated to respond first to a medical emergency). She heard the alarm bell and began making her way to I wing. She heard the call for Hotel 1 as she was on her way there. She said she arrived at the cell and saw the woman on the floor. She said she left the cell briefly to use her radio to call for the resuscitation bag and an ambulance. She then checked for a pulse and took over applying chest compression to the woman. She said the nurse manager relieved her and she left the cell as the paramedics arrived.

The acting Healthcare Manager said she responded to the alarm bell as well. When she arrived at the cell she helped escort the prisoner from the room and then took over from the nurse and applied chest compressions until the paramedics arrived. She said the woman was cyanosed and there was no sign of a pulse.

The doctor said she was asked to attend I wing at approximately 9.00am on 28 July. She found the woman lying on the floor of her cell being resuscitated by an officer, the healthcare manager and another nurse. She said she was told that the woman had hanged herself using a belt in the shower area of the cell. She said she checked for vital signs but could find no pulse. She said that she appeared bluish and was not breathing naturally. Her pupils were dilated and fixed. The doctor said the paramedics took over without success. The heart monitor showed a straight line (indicating no electrical activity in the heart) and the woman was pronounced dead at 9.17am.

Another SO said he responded to an alarm bell at approximately 8.55am. When he arrived at the cell and found the woman had apparently attempted suicide, he said he immediately used his radio to inform the communications room and call for an ambulance. He also asked an OSG (Operational Service Grade to start an incident log at about 9.00am.

The third SO said he responded to the alarm bell in his capacity as the Security SO. He arrived on I wing and saw one of the SO's calling for an ambulance on his radio. He said he told an officer to go to the centre to collect the resuscitation bag. He said he made his way to the gate. On the way he used his radio to instruct that all vehicle moves should be stopped to allow the ambulance to enter. He said that the ambulance was making its way through the sterile area when he arrived at the gate. He said he directed it through and then obtained the 'total override' keys so that he could leave both gates unlocked to allow the ambulance to leave quickly. The SO for security said that he remained at the gate until about 9.20am when he was told that the woman had died.

3. The prison's immediate response

A fourth SO said the healthcare officer and the paramedics left the woman's cell at about 9.20am. She said she locked the cell and stood outside it while the other prisoners were unlocked and taken to the association room. The healthcare officer and the paramedics briefly re-entered the cell to complete some paperwork at 9.23am. At about 9.28am, she said the curtains in the cell were closed, the woman was covered with a clean sheet and the healthcare officer and the paramedics left the cell. She said the cell was then locked and sealed. The police and the Coroner arrived at about 10.45am and the cell was unsealed for them to begin their investigation. She said the cell was resealed at 11.25am when the police and Coroner left. It was opened again at 11.35am when the woman's body was taken to the mortuary.

A Principal Officer (PO) was the Orderly Officer on 28 July. She said that she attended I wing when she heard the alarm at approximately 8.55am. She said an officer was in charge of movements in and out of the woman's cell when she got there. The PO said she told wing staff to make sure the other prisoners were accounted for and to check those who were the subject of ACCT (the self-harm monitoring procedures). She said member of the Care Team were present on the wing and spoke to staff as they became available. Some distressed prisoners were taken to the healthcare centre for treatment. The PO said that, as soon as the woman was pronounced dead, she went to the Centre and drew out the death in custody contingency plans for the Orderly Officer. She said a hot debrief was led by the Governor at 10.30am. Following that, she continued to collect statements and other evidence as part of the contingency plan.

The Duty Governor on 28 July said he was chairing a meeting when he heard the alarm bell. He said he attended I wing and was briefed by a colleague monitoring the movements in and out of the woman's cell. He said he spoke to all staff who were present and briefed the Governor when he arrived at the prison. He said he was told the woman had died at 9.17am. He then activated the death in custody contingency plans using his office as a base.

The completed death in custody contingency plans show that procedures to review the cases of those prisoners thought to be at risk of self harm were begun at 9.10am. The Governor alerted the Prison Service's National Operations Unit when he arrived at the prison after 9.05am. Extra members of the Care Team were called to the wing to see staff and prisoners at 9.20am. The Governor started making arrangements for the woman's next of kin to be informed of her death at 9.34am. As the woman's family lived in York - some distance from Low Newton - it was decided to contact staff at Askham Grange prison (just outside York), and ask them to visit the woman's family as soon as possible. The Coroner was informed of the woman's death at 9.40am. A hot debrief for staff was held at 10.30am. Notices reporting the death were put up in the prison some time after 11.00am. Prison Service Safer Custody Group and the media relations unit were told at 11.10am and 11.00 respectively.

The Deputy Governor of Askham Grange, who eventually broke the sad news to the woman's mother, said he was not contacted until 11.00am. He waited for the Chaplain to arrive at the prison and then they left for the mother's house. They arrived at the house at about 1.00pm to find only the woman's younger brother at home. The woman's mother arrived home about 20 minutes later and was told of her daughter's death at about 1.30pm.

The other prisoners on the wing were unlocked at about 9.20am and taken to the association room where they were given tea, snacks and tobacco and told what had happened. All the staff and prisoners who were interviewed by my investigators said they were pleased with the level of care and support offered to them after the woman's death.

4. What other prisoners said

A prisoner that said she travelled to Low Newton in the same escort van as the woman,. said it was the first time she had met the woman although she knew her brother and the woman knew who she was. The prisoner said she did not really speak to the woman on Monday evening but she spoke to her through her door on Tuesday morning and asked her if she was okay. She said that the woman seemed fine and was laughing with her. The prisoner was asked if she was aware if the woman had any trouble with any of the other prisoners. She replied, "Well there's lots of things going about isn't there but you don't know what to believe do you?"

The prisoner that helped with resuscitation said she first saw the woman on the morning of Tuesday 27 July. She said, because the woman was being kept in her cell, there was some speculation about the reasons why. She said that the prisoners with her dismissed the speculation as prison rumour. She said she saw the woman come to her door when other prisoners went past. She said the conversation they had with the woman seemed to be nice and she did not hear any derogatory remarks. The prisoner said she also saw the woman in the treatment room that morning. She said she was chatting to women from other wings and seemed "perfectly happy". She said she had experience of working with suicidal people outside prison and, in her opinion the woman had not appeared depressed or suicidal. She said there were other prisoners who were obviously very depressed and very upset and the woman did not behave like these women. She said she was aware that the woman was "behind her door" but, because she was not banging on the walls or "kicking off", she assumed she was happy with the arrangement.

The prisoner that spoke to the woman through her door said she spoke to the woman through "a couple of times" when she arrived on the wing on Monday 26 July. She said she was "very upset" about being in prison and had mentioned the length of her sentence. She said she spoke to the woman again through her door on Tuesday 27 July and the woman "seemed okay". She said she saw the woman sitting on the end of her bed and the woman told her that she was okay. She said other prisoners spoke to the woman during Tuesday as they passed her door. The prisoner said she had heard rumours on the wing that the woman was a "nonce". She said she ignored the rumours but was aware that the woman had some trouble with another prisoner. She said she did not know the name of this prisoner but described her as having long dark hair and being in her forties. She said she had seen this woman make "snidey comments" to the woman as she passed her cell but had not seen her go to the woman's door. The prisoner said one of the words the woman said was "nonce". She said she didn't think anyone took any notice of what the woman was saying.

A prisoner in the cell next door to the woman said she spoke to the woman through her door during Tuesday 27 July and said hello and asked her what she was in for, which was a normal introduction in prison. She said the woman seemed "fine" and "perfectly happy". The prisoner said she had not heard any other prisoners calling out of the windows at night, but she thought that the woman had a "bit of ruck" with another prisoner. She said there were rumours on the wing that the woman was a "nonce". She said she did not think that the other prisoner gave the woman a lot of trouble but that she was saying "nonce" every time she walked past her cell. The prisoner was able to name the prisoner causing the woman concern.

Another prisoner said she saw "one or two" other prisoners talk to the woman through her door. She identified one prisoner as talking to her a couple of times. She said she thought

she was “trying to be friendly”. She said she did not notice anyone saying anything “untoward” about this prisoner.

The prisoner that caused the woman concern was interviewed at HMP&YOI New Hall where she was transferred after the woman’s death. She said she saw the woman when she arrived on I wing from Reception on Monday 26 July. She said the woman was crying and “very upset”. The prisoner said that two officers came to her cell that evening and asked her if there would be any trouble if she and the woman came into contact with each other. She said she told them there “probably would” be. She said she and the woman had “had words” outside prison. She said she was on the same landing as the woman and had to pass her cell to collect her meals and go to association. Initially in the interview, the prisoner said she did not see or speak to the woman at all because she was “behind her door”. She said that another prisoner had told her that the woman wanted to talk to her but that she had refused to go to her door. Later in the interview, the prisoner said that the woman had shouted to her when she passed her cell. She said:

> “And she shouted, where were you for the kids anyway, and I’m not frightened of you, and I said I’ll just see you when you get out.”

The prisoner said she felt guilty when she heard that the woman had died because she was the reason she was in her cell. She said she felt “terrible”.

The prisoner made a phonecall to her mother at 6.57pm on Tuesday 27 July. She told her mother that the woman had arrived at Low Newton and was being kept behind her door. She said the woman had been crying and was afraid she was going to “get done in”. Later in the conversation, the prisoner’s mother asked her what would happen to the woman. She replied that she thought she would be “shipped out” (transferred to another prison).

The prisoner’s daughter was also interviewed in New Hall. She said she was in Low Newton at the same time as the woman but on a different wing. She said she did not see, speak or pass any messages to the woman during this time.

A prison ‘Insider’ (a prisoner who befriends other prisoners when they arrive in prison), said she saw the woman in reception on the evening of Monday 26 July. She said the woman was obviously upset, but she thought that staff looked after her well.

Another prisoner said she had known the woman for many years. She said she did not see her in Low Newton but that the woman was not the sort of person to become depressed. This prisoner was clearly unhappy about responding fully to my investigator’s questions on tape. She asked the investigator to tell her friends mother, “I’m sorry, but I’m in prison.” She made a phonecall to her brother at 7.04pm on Wednesday 28 July. She told him that other prisoners had been “at the windows the last two nights, torturing the poor lass”.

5. Consideration

This woman was seen by a number of staff during the evening on Monday 26 July and throughout Tuesday 27 July. She became upset during reception procedures and told staff that she was worried about the length of her sentence. She later confided to wing staff that she was worried about a potential conflict with another prisoner. A decision was taken to keep the woman in her cell until Wednesday morning when the other prisoner would move to another wing. It appears that staff made great efforts to reassure the woman and to keep her informed of what was happening and why. The woman was treated in a caring and compassionate way and an immediate attempt was made to get assurances from the prisoner that she would not cause trouble. An officer made sure that the women did not accidentally meet at the healthcare centre. No member of staff and no prisoner interviewed said that there was any indication that the woman was depressed or contemplating suicide or self-harm. Most people who had contact with her on Tuesday 27 July agree that she appeared to be quite happy. The Chaplain said the woman was tearful when she saw her on Tuesday late in the morning, but that the woman had told her that the thought of her family and her children would be enough to dissuade her from suicide or self-harm.

There is evidence from other prisoners that the prison that caused the woman concern verbally abused the woman when she walked past her cell. The woman also refers to the prisoner shouting at her and calling her a 'nonce' in the letter she wrote to her mother on Tuesday 27 July. The prisoner herself admitted in interview that she had spoken to the woman through her door on at least one occasion. The size of the observation hatch means that it is impossible for a person in the cell to see who is walking past the door unless one or other of them is standing by the hatch. Another prisoner told her brother that other prisoners had been calling out to the woman through their windows at night. I have seen no supporting evidence that other prisoners verbally bullied the woman although those interviewed admit there were 'rumours' circulating on the wing about why the woman was kept in her cell. It is not known what the prisoner caught on CCTV on Wednesday morning said to the woman. Although it is clear that some verbal bullying of the woman did take place, it is impossible to say to what extent it contributed to her state of mind on the Wednesday morning.

The woman told both a nurse and the Chaplain, when directly asked, that she had no intention to self-harm or thoughts of suicide. She did not present as particularly depressed to other staff or prisoners. Nevertheless, there were a number of factors that might have indicated that she should be regarded as a risk. She was undergoing detoxification, it was her first custodial sentence, she was concerned about threats from another prisoner, she missed her children and she was concerned about the length of her sentence. Neither the first reception health screen questionnaire nor the cell sharing risk assessment form is structured to aid staff to report these observations coherently. Both forms rely heavily on the prisoner telling staff they are at risk or there being some obvious psychiatric history or previous incidents of self harm in the documents available to staff. Typically, there are few of these available. I do not direct any blame whatsoever at staff in Low Newton for their actions. But I believe the Prison Service should encourage staff to take a broader view of risk factors, notwithstanding what prisoners themselves may say. With the benefit of hindsight, the factors in the woman's life that I have listed above surely did indicate that she was at some risk.

Prison Service health report draws attention to several concerns about the opiate withdrawal management (detoxification) regime prescribed for the woman at Low Newton.

I note first that there was no attempt by medical staff on reception to corroborate the woman's account of her medication and recent drug use. The woman was not given any opiate withdrawal medication on her first night, and there is no evidence to show staff checked that she had taken her methadone prescription before she went to court that day. I particularly note the comment that:

> "Dihydrocodeine was prescribed from 27 July reducing by 30mg daily which would have been inadequate to control withdrawal in someone in receipt of a methadone prescription of this level, particularly when this was being taken under 'supervised consumption'."

The woman's initial drug screening test showed a positive result for methadone, opiates, cannabis and benzodiazepines. There is no evidence to show that this drug use was investigated. The report makes the point that these drugs were used in the community and would have required cautious withdrawal management to avoid an increase in anxiety. She said:

> "When in withdrawal women are impulsive, volatile and given to sudden changes of mood, all of which increase the risk of self-harm attempts. Some of this distress and unpredictable behaviour can be lessened, although not completely eradicated, by adequate withdrawal regimes for opiates and benzodiazepines. At the time of the woman's admission to Low Newton these regimes were not being prescribed in line with the practice in other women's prisons…"

Again it is impossible to tell what effect the inadequacy of the woman's opiate withdrawal regime had on her state of mind. But clearly it would not have helped her cope with any anxiety that she had about being in prison.

The report also notes that the woman was in effect confined to her cell during her time in Low Newton. It is recognised that it is undesirable for women to be isolated in the first four weeks of withdrawal. An instruction to this effect was issued in June 2003 by the then operational manager for the women's estate. In response to this, the Governor of Low Newton issued a Staff Information Notice on 9 June 2003. Paragraph one states that a woman undergoing detoxification who is charged with an offence under Prison Rules should not be "fitted" for cellular confinement as a punishment. The notice concludes, "The vulnerability of these women cannot be underestimated." Although the notice is intended to cover the general management of prisoners undergoing detoxification, all three paragraphs refer to disciplinary situations. No parallels are drawn with other reasons for confinement to a cell, for example for a prisoner's own protection.

I fully accept that staff decided to keep the woman in her cell in order to protect her from conflict. This was intended as a kindly and protective measure. I am also conscious that every effort was made to explain the reasons behind this to the woman and that she was aware that it would only be for a short while. However, the effect was to impose on the woman, a brief period of what was - in effect - cellular confinement. As the Governor's notice indicates, this is known to exacerbate the anxieties and impulsive behaviour of women withdrawing from drugs. Accordingly, I have included in this report a recommendation that staff should be careful that women in the early stages of detoxification do not, for whatever reason, spend periods in isolation.

I note that, since September 2004, Low Newton has had different doctors in post, and that the withdrawal and maintenance regimes for drug users are now in line with other public

sector women's prisons. I endorse the recommendations made by the specialist from Prison Health in their report and they appear below with others.

I also draw attention to the clinical reviewer's observations and recommendations made in his clinical review (not published). I note particularly his concerns about the quality and availability of resuscitation equipment and the ability of staff to use it. These concerns are confirmed by the reports of two Healthcare Senior Officers from Frankland prison (commissioned by the Governor of Low Newton and not published) which say that the emergency medical bags were poorly stocked and staff did not know how to use them. I have made recommendations in the light of these concerns.

The clinical review confirms that the prisoner and the members of staff who attempted to revive the woman acted appropriately, and that nothing more could be done to try to save her. The ambulance arrived promptly and correct steps to ensure its swift entrance and exit from the prison were taken.

The prison's immediate response to the woman's death was in accordance with local and national guidelines. The efforts to support staff and prisoners were very good. Indeed, the prompt way prisoners were let out of their cells for tea, tobacco and support should be commended as good practice to the Prison Service as a whole. More generally, the care and professionalism of the staff in reception and the induction wing towards new receptions is exemplary.

The woman had given her mother's name and contact details as next of kin on her arrival at Low Newton. Given that her mother lived so far from Low Newton, I also commend the decision to ask staff from Askham Grange to inform the family of her death. I believe this sad responsibility is properly that of the Prison Service not of the police. However, I consider that the delay between the pronouncement of death at 9.17am and the call to the Deputy Governor at Askham Grange at 11.00am was unacceptable. Following every death, the priority for the Prison Service should be to contact the next of kin. Prison staff are well aware that information can travel from a prison very swiftly, and every effort should be made to make sure that the family are the first to hear the sad news. In this case, regrettably, her family were not the first to know of the woman's death. I know that fact has caused them no little distress.

I do not think a formal recommendation is required, but as a matter of good practice the Governor of Low Newton will wish to review the contingency plans for a death in custody to ensure it gives appropriate priority to informing the next of kin.

I note that since the woman's death the rail above the shower door has been boxed in on all showers in the induction unit.

6. Recommendations

- I recommend that any future situation in which it is known or suspected that there may be trouble between two prisoners, and which requires special management measures, should be reported to the prison's Safer Custody Manager who can investigate and decide on appropriate action.
- The Governor should remind staff that any decision to isolate women undergoing detoxification should only be made after careful consideration of the risks involved and after ensuring that adequate support during this vulnerable period is provided. (Prison Health advice is that the use of cellular confinement or any equivalent regime that seriously restricts 'time out of cell' should never be used for a woman in the first four weeks of withdrawal or stabilisation.)
- The system of recording clinical information by both medical and nursing staff should be reviewed in order to ensure that appropriate standards are met.
- All healthcare staff should be trained to an appropriate level of competence in the use of resuscitation equipment and a range of adequate and serviceable equipment should be available for their use.
- The local suicide and self-harm prevention strategy document should be reviewed in order that outdated references can be amended.
- The clinical management of substance misuse of women at Low Newton should progress in line with the standards and practice in use in other public sector women's prisons. Assessment of substance misuse, started at reception, should progress during the following five days, during which stabilisation takes place, prior to a care plan being agreed with the patient, with regard to an appropriate withdrawal or maintenance regime. Community prescriptions must be confirmed, and the dose and duration of prescribing reflected in the withdrawal (or maintenance) management care plan. Positive urine tests should match the reported history, and discrepancies clarified, to ensure all withdrawal regimes are put in place.
- The Governor should write to the prisoner who attempted to revive the woman, commending her actions when the woman was discovered.
- The NOMS Safer Custody Group should consider the feasibility of introducing an accredited basic first aid training course for prisoners.