PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

# Investigation into the circumstances surrounding the death of a woman at HMP Full Sutton in July 2012

## *Our Vision*

‘*To be a leading, independent investigatory body,*
*a model to others, that makes a significant contribution*
*to safer, fairer custody and offender supervision*’

This is the report of the investigation into the death of a woman at HMP Full Sutton in July 2012. She was 44 years old and was found late in the evening hanging from cell window bars. I offer my condolences to family and friends.

The woman, although born male and still male in law at the time of death, had been living as a woman at Full Sutton for nine months as preparation for gender reassignment. Out of respect to her wish over that period to be referred to as a woman, and in accordance with Department of Health guidance for transgender persons, she is referred in this report by her preferred gender.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a clinical review in to the woman's care. Full Sutton cooperated fully with our enquiries.

The woman had been a category A prisoner for more than twenty years. Her category and sentence progression caused her much frustration, and previous applications to reduce her category had been refused. Her category was due for review again in August 2012. On the afternoon of her death, a prisoner made an accusation of sexual assault against her. She was found hanging in her cell later that night. In a letter found in her cell, she wrote of alleged blackmail related to the sexual assault and how these accusations would have affected her category review.

I am concerned that officers apparently had relatively little awareness of relationships and sexual activity between prisoners on the woman's wing, and were unable or unwilling to challenge some inappropriate behaviour. The investigation concludes that it is likely an accusation of sexual assault triggered her actions in July, as she appears to have believed it would block her sentence progression and progress towards gender reassignment. However, in all the circumstances it would have been difficult for prison staff to foresee or prevent her apparent suicide.

Although it would not have affected the outcome in this case, there is a need to improve some emergency procedures. There is also a need for families to be compensated for reasonable funeral expenses in line with Prison Service guidance.

This version of my report, published on my website, has been amended to remove the names of the woman who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **July 2013**

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## SUMMARY

1. The woman was sentenced to life with a minimum period to serve of six years, for the kidnap and sexual assault of a minor in 1991. In 1996, she was convicted of the rape of another prisoner and received an eight year concurrent sentence.

2. The woman was a category A prisoner, the highest security category and one which is reviewed annually. Whitemoor and Full Sutton prisons had recommended that her category should be reduced to B for the previous two years, but the recommendations were not accepted by the National Offender Management Services (NOMS), Director of High Security. She seemed resigned to the decisions, but was frustrated about her slow sentence progression.

3. The woman transferred to Full Sutton in June 2010, and settled well and continued to participate in offender treatment programmes. She had first started talking about possible gender reassignment treatment in 1996 and, in early 2011, enquired actively about starting the process. In October 2011, she signed a compact agreeing to live as a female, the first step in gender reassignment. She was described as being fully committed and enthusiastic about the process, and met weekly with the Diversity Manager for support. Although she had previously been the subject of suicide and self-harm prevention procedures, she expressed no intention of harming herself at this time or in the weeks leading to her death.

4. Throughout her time in prison, other prisoners alleged that the woman sexually assaulted or groomed other prisoners, and often spoke in an inappropriately sexualised way. She also made similar allegations against prisoners and complained that she was being victimised by officers.

5. One afternoon in July, a prisoner complained to officers that the woman had sexually assaulted him and she was locked in her cell pending investigation and a disciplinary hearing. The possibility of taking her to the segregation unit was discounted for operational reasons. She claimed that the other prisoner was blackmailing her for a bracelet and money in exchange for which he would withdraw the allegation. At 9.00pm, an officer saw her vomiting in her cell which she explained was the result of eating too many biscuits. No action was taken.

6. At 10.55pm that evening during a routine check the woman was found hanging in her cell. Resuscitation was attempted, but was unsuccessful.

7. At the time of her death, the woman was being considered for re-categorisation, as well as gender reassignment. She wrote that she was worried that the allegation of sexual assault would damage her sentence progression and her change in gender. There is no record that officers were supporting her through this vulnerable time or that inappropriate sexual behaviour on the wing was challenged appropriately. We make a number of recommendations accordingly.

8. Although it does not appear that this would have affected the outcome for the woman, we also note that the emergency response was slowed down by the lack of availability of emergency equipment in residential areas, difficulty opening a

sealed key pouch and failure to call an ambulance immediately. The cord should also have been removed from her neck before resuscitation started. The report concludes that her death could not reasonably have been foreseen.

## THE INVESTIGATION PROCESS

9. The Ombudsman's office was informed of the woman's death on 13 July 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with any relevant information to contact him. No one came forward.

10. Another investigator visited the prison on 19 July, on the original investigator's behalf, and met the Governor, his deputy and the Head of Healthcare. She also met the Chair of the Independent Monitoring Board (IMB) and the Chair of the POA (the prison officers' trade union).

11. HM Coroner for East Riding and Kingston Upon Hull was informed of the investigation and has been sent a copy of this report.

12. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the clinical care that the woman received in prison. The clinical reviewer received copies of all the relevant medical and prison documents.

13. The investigator and a colleague visited Full Sutton twice in September to conduct interviews with staff and prisoners. He reviewed the woman's prison records. The investigator and his colleague fed back to Governor throughout the course of the investigation and later confirmed this in writing

14. During the investigation the investigator liaised with officers from Humberside Police. The police provided a log of the CCTV footage showing the movements of the woman and other prisoners on the afternoon of the incident. Unfortunately, the coverage of three key incidents that afternoon was damaged when the footage was being downloaded and could not be reviewed by police or the investigator.

15. Many of the issues raised in this report involve and cover allegations which are not proven.

16. One of the Ombudsman's family liaison officers contacted the woman's parents to tell them about the investigation. The family liaison officer and investigator later met her parents, who asked that the investigation address the following points:

    - Why was she left for two hours after vomiting at 9.00pm?
    - Was she being blackmailed by other prisoners?
    - Was her heart condition monitored appropriately? (This aspect of her care is covered in the clinical review, annexed to the investigation report.)

17. The woman's family received a copy of the draft version of the report as part of the consultation period. Written representatives were provided by the family in response to the investigation findings. The family, although finding the report distressing to read, found it detailed and agreed with the issues identified.

## HMP FULL SUTTON

18. Full Sutton is a purpose-built maximum security prison. It holds up to 608 category A and B prisoners serving a minimum of four years. Healthcare services are commissioned through the local Primary Care Trust. There are registered general and mental health nurses, as well as a nurse prescriber (a nurse who is qualified to prescribe medication) and daily GP cover. There is an inpatient unit with six beds and 24 hour nursing cover.

### HM Inspectorate of Prisons (HMIP)

19. HMIP conducted an unannounced full follow up inspection of Full Sutton in October 2010. HMIP found that, since the previous inspection in 2007, relationships between staff and prisoners had improved and that most prisoners reported feeling safe. However, they reported that, although 8% of prisoners surveyed regarded themselves as gay or bisexual, no work had been undertaken to address their needs.

20. The Inspectorate described the security department as well-resourced and impressive. Security staff held briefings with residential staff three times a week and security reports requiring further actions were dealt with efficiently.

### Independent Monitoring Board Report

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The IMB did not specifically mention sexuality or gender issues in its most recent report (published in 2011), but was satisfied that the management team were committed to equitable treatment of all prisoners. The IMB commented that there is a proactive approach to ensure that every prisoner feels safe and respected. The IMB also recognised efforts to tackle violence in prison and to manage those at risk of suicide or self-harm.

### Previous deaths at HMP Full Sutton

22. There were six deaths at Full Sutton in 2011, and the woman's death was the first of three deaths in 2012. Apart from the ongoing investigation into a homicide in early 2011, all of the other deaths were through natural causes. After a death in 2009, we recommended that an ambulance should be called as soon as possible in an emergency, a recommendation we repeat in this report. The prison did not contribute to the cost of the woman's funeral in line with national guidelines, which was also the case following a natural cause death at Full Sutton in September 2012. There were no other similarities between the circumstances of the woman's death and the findings of the other investigations.

## Transsexual prisoners

23. Prison Service Instruction (PSI) 07/2011, The Care and Management of Transsexual Prisoners, covers medical treatment, living in an acquired gender role and sets out the legal position. Gender reassignment is considered to be a protected characteristic under the Equality Act 2010, so prisoners must not be discriminated against or harassed because of it.

24. The PSI is not prescriptive, but suggests that a prisoner should have a monthly review with their personal officer and a quarterly review with their designated liaison officer.

25. The PSI requires that governors permit prisoners who consider themselves transsexual and who wish to begin gender reassignment to live permanently in their acquired gender. The PSI states that:

> "Permitting prisoners to live permanently in their acquired gender will include allowing prisoners to dress in clothes appropriate to their acquired gender and adopting gender appropriate names and modes of address … An establishment must allow transsexual people access to the items they use to maintain their gender appearance at all times."

## Categories of prisoners

26. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category D: open conditions, prisoners who can be trusted not to try and escape.

27. Due to the seriousness of the original crime and a further sexual offence in custody, the woman was in security category A prisoner. Category A prisoners have their security category reviewed annually by the National Offender Management Service (NOMS), Category A Review Team and an advisory panel, but the Director of High Security is responsible for approving the downgrading of a Category A prisoner. Before approving a confirmed Category A or Restricted Status prisoner's downgrading the Director must have convincing evidence the prisoner's risk of re-offending if unlawfully at large has significantly reduced. This may be evidence from the prisoner's contact with others or participation in offending behaviour work that shows the prisoner has significantly changed their attitudes towards their offending or has developed skills to help prevent similar offending.

## KEY EVENTS

28. On 15 March 1991, the woman was convicted of the kidnap and sexual assault of a minor at Crown Court and, on 5 July, received a life sentence with a minimum period to serve of six years (the tariff) before release could be considered by the Parole Board. The tariff expired on 5 July 1997. She had served several previous prison sentences for offences including indecent assault, importuning and robbery.

29. In the first two years of her sentence, the woman transferred between HMP Lewes, HMP Wormwood Scrubs and HMP Albany before going to HMP Wakefield in January 1992. In March 1994, she was transferred to HMP Full Sutton. In August 1995, she was charged with the rape of a fellow prisoner, and was convicted in February 1996 and sentenced to an eight year determinate sentence to run concurrently with the existing sentence. She transferred to Frankland in October 2002 but, after nine months, transferred to Whitemoor and remained there until June 2010.

30. During the woman's time in custody a number of other prisoners made allegations against her which were sometimes proven. These included sexual assault, the use of suggestive and inappropriate language, bullying and grooming other prisoners. She also made similar allegations against other prisoners and complained of staff victimisation.

### Previous Assessment, Care in Custody and Teamwork (ACCT)

31. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Regular multi-disciplinary reviews should be held to review risk and the prisoner's progress.

32. Between 1994 and November 2011, prison staff opened ACCT procedures for the woman on 21 separate occasions, often as a precautionary measure, to help her through difficult periods. On two occasions in 2005 an ACCT was opened after she self-harmed by taking overdoses.

33. In November 2008, an ACCT was opened when the woman felt low and ostracised by other prisoners. However, she said she would not kill herself because she was against the act of suicide. Twice in 2009, an ACCT was opened when she refused to take prescribed heart medication for a week. This happened again in May 2011. The last ACCT document was closed in November 2011. She was not subject to ACCT procedures at the time of her death.

### Categorisation

34. The woman's category A status was reviewed annually. In November 2009, staff at Whitemoor recommended a reduction to security category B. Within days of

the recommendation, she was accused of sexually grooming a prisoner from another prison and the application for a change in security status was rejected by the Director of High Security in January 2010. She told staff that she was expecting this but was not happy about it. It was noted that she did not take the decision well, and focussed on the negative aspects of the review rather than the positive comments made by the staff who had supported her application.

35. On 8 June 2010, the woman transferred back to Full Sutton to undertake the sex offender treatment programme (SOTP). In August, she told prison staff that she would lose all hope of ever being released if her category was not downgraded. She said that she had no intention to commit suicide or to self-harm, but would just fade into the prison system and get on with life. In October 2010, she again told officers that she did not believe she would ever get out of prison.

36. A further review of the woman's category A status took place in June 2011. The local review panel at Full Sutton recommended a reduction in security category to B, but the application was rejected by the NOMS Director of High Security. The Director said he recognised that she had no adjudications (prison disciplinary offences) in the previous year and was an enhanced regime prisoner, but he was concerned about the allegations of grooming that had led to the previous rejection. There was also security intelligence relating to sexual issues. She said she had expected the outcome, and that it was business as usual. Officers did not record any concerns about her response to the news.

**Gender reassignment**

37. The woman had talked about gender reassignment since 1996, when she said she would kill herself if she had to continue to live like a man. In early 2011, she asked about starting the process of gender reassignment. In October, she signed an agreement to live as a female, the first stage of gender reassignment, which meant that she had to live as a woman for two years. From that point, she began to wear female clothing on the wing and asked to be referred to as a woman. The Diversity and Equality Manager met her weekly to review her needs. In a statement to police, he said she, "… was fully committed and enthusiastic about the transgender process and at no time did she express any interest or tendency to self-harm".

**Move to G wing**

38. On 31 October, the woman alleged that she had been raped by another prisoner on B wing and was moved to G wing, the induction wing, pending an investigation. The incident was reported to Humberside police, who concluded that there was no evidence of rape and no further action was taken.

39. On 3 November, an officer opened ACCT procedures because the woman said she felt depressed and staff had "closed ranks on her" after the rape allegation. During a case review the following day she said she was depressed and had placed a noose around her neck which had broken, so she threw it away. She

said that her actions had scared her and would not do anything else like it.

40. During an ACCT case review on 7 November, the woman said she was still feeling low, but was supported by the mental health team. At a review on 11 November, she said she had no thoughts of self-harm, but became verbally aggressive and the review was stopped. She apologised during a review two days later and said that she felt much better, because she could see "light at the end of the tunnel" in relation to her gender reassignment. The ACCT document was closed and a post-closure review was scheduled for 22 November, at which no further concerns were raised.

41. Officers opened a violence reduction and anti-social behaviour dossier on 21 November (designed to monitor and support prisoners who may be at risk of bullying or anti social behaviour). As the woman was undergoing gender reassignment and because of the allegation of rape, it was decided that officers should monitor her until she was settled on the wing. Prisoners told officers that she was a sexual predator and made frequent sexual comments to other prisoners. It was then agreed that she should move to C wing, where it was considered she would receive more support during the early stages of the transgender process.

**Move to C wing**

42. The next day, 22 November, the woman moved to C wing. An officer introduced herself as the woman's personal officer and because of her special circumstances she was assigned an additional personal officer. (Each prisoner should be allocated a personal officer to support them and be their first point of contact.) She was told that her transgender status would be a learning curve for all, both officers and prisoners.

43. During a violence reduction strategy review on 29 November, the woman said that she felt persecuted and that the prison was not doing enough about her transgender issues. She reported that she had received threats from other prisoners and some were unhappy that she wore women's clothing. Officers agreed to challenge inappropriate behaviour. During a review on 6 December, officers reported that she was more settled on the wing and was beginning to receive support from other prisoners, but continued to feel threatened by prisoners on other wings. At a review on 4 January 2012, she told officers that other prisoners continued not to accept her transgender status and she expressed an interest in transferring to HMP Frankland where she understood there were other transgender prisoners. At a review on 1 February, she said that she remained despondent but reported no issues with other prisoners on the wing, and overall felt safe. It was agreed that the violence reduction and anti-social behaviour dossier should be closed.

44. On 22 February, the IMB responded to a query from the woman in which she asked for clarity about the funding for her gender reassignment treatment. After making enquiries the IMB advised her that the local PCT did not fund gender

reassignment treatment.

45. On 15 March, the woman's personal officer made her first entry in the woman's prison record, four months after she was appointed. She wrote:

> "She has not had much need of me during her time on C wing so far. Apart from the odd query regarding the ordering of shoes or getting a job she had has quite a settled period. I still have not observed her wearing female clothing around the wing very much but is doing so in cell…"

46. On 1 April, the woman told an officer that she could not attend healthcare for her medication as other prisoners had threatened to attack her. She could not name the prisoners. The security department was informed but was unable to find any evidence to support the allegations. Later that day, her personal officer noted that she had observed her wearing a skirt around the wing and that none of the other prisoners had complained about her transgender process.

47. A security information report was submitted on 5 April, suggesting that prisoners on the wing were selling their medication in return for sexual favours. The report alleged that Prisoner A, one of the wing's younger prisoners, was being groomed by another prisoner. There was no recorded outcome from this security information report.

48. On 26 May, the woman's personal officer noted that the woman remained frustrated about the slow progress of the gender reassignment process. On 6 June, she wrote a letter to her family enclosing visiting orders and telling them that she had recently contacted her probation officer to seek information about the sort of places she would be allowed to live when she was released.

49. Preparations for the woman's next category review started again in April. On 14 June, she submitted representations to the local review board indicating that she had recently completed a number of offender treatment programmes including the sexual offender treatment, drug and alcohol awareness programmes, had spent some time on the dangerous and severe personality disorder unit at Whitemoor, and was currently taking part in the healthy sexual functioning programme. She said she was focussed on her gender reassignment, hoped to move to a therapeutic community prison, if her category was reduced to B, and was preparing resettlement plans with her family and probation. Although a number of reports were being prepared for the review panel, no date had been set for the review. Representations had to be in by 14 July, so it seems unlikely that the review would have been held before August.

50. Prisoner B, a prisoner on C wing, said that at the beginning of June the woman told him that she found another prisoner on the wing attractive. Prisoner B said he had seen her follow him into the showers and that the prisoner had shown her what was "on offer". Prisoner B said she had sex with the prisoner on 12 July. In the intervening weeks Prisoner B said that she had been buying items from the

prison shop (known as canteen) for this prisoner.

51. On 18 June, the woman's personal officer noted that the woman had started the healthy sexual functioning course and was finding it useful. She told the officer that she would continue to work towards becoming a category B prisoner and seek a move to either HMP Grendon or HMP Dovegate in order to undertake more therapy work. She acknowledged that this would be a long process but felt better for having a plan in place for her life and her gender reassignment. This was the last entry in her case notes.

52. Prisoner C, a prisoner on C wing, told the investigator that Prisoner A had a reputation for taking advantage of older men. He said that Prisoner A would run up debts and then allege that he was being bullied or extort money to repay them. The prisoner said that the woman had told him that she was close to Prisoner A, and that the two of them had had a sexual relationship for a number of weeks. He said that she was flattered that the prisoner was interested in her, and at first he said that he did not believe the extent of their relationship until he saw them engaging in sexual activity one day in the prisoner's cell. He alleged that the woman was giving the prisoner canteen and extra food from the servery.

53. Prisoner C said that prisoners on the wing were aware that the woman wanted to be re-categorised to B and that her next review was due soon. He said that there had been rumours on the wing for months about someone blackmailing her for a gold bracelet and for £5,000 as she was so vulnerable in the run up to the review. He said he had discussed the rumours with her and warned her to be careful.

54. On 3 July, the woman alleged she had been bullied by another prisoner, who made a counter-allegation. A Senior Officer said:

> "My experience of the woman was that she kept herself to herself really. If ever you asked if she was okay, always yes, you know. Worked a little bit on the servery, and then was a wing cleaner, associated with a few prisoners on the wing … I wasn't aware of anything, any sexual relationships or anything involving Prisoner A and her."

55. On 7 July, the woman spoke to her mother, seemed fine and asked her mother to send £500. She spoke to her mother again on 10 July, and confirmed that the money had been received and again she seemed fine. She had over £1,000 in her personal account when she died.

56. Prisoner D, a prisoner on C wing, told the investigator that a few days before her death, the woman told him that she was having a "mess about" with Prisoner A and Prisoner E. He said that he understood that she had been having sexual relations for a month or so with both of them before she died. He said that she had convinced herself she was in a relationship with Prisoner A, but was sceptical about his motives.

**12 July**

57. Prisoner B spoke to the woman at lunchtime on 12 July, and warned her about spending too much time with Prisoner E. He said that this prisoner had blackmailed him and had sex with him in exchange for medication in the past.

58. Prisoner C told the investigator that when he went back to the wing after work at about 3.30pm, the woman seemed fine. He said that, late in the afternoon of 12 July, he saw Prisoner A sitting on his bed and she was sitting on a chair in his cell.

59. In his police interview, Prisoner E said he did not know the woman well, but socialised with Prisoner A. He said that at around 2.30pm he saw her talking to Prisoner A through the cell door. He said that at about 3.15pm to 3.30pm he saw her sitting in his cell, and she was there for at least ten minutes. He said that he and the prisoner ate together that evening. Prisoner A was quiet and said he was going to healthcare, which he did a short time later. The next day he said that he heard he had made an allegation of sexual assault against the woman. He denied to police that either he or the other prisoner were in a relationship with her but was aware that there were rumours on the wing about them. He denied being involved in blackmailing, but said he had heard that two other prisoners and Prisoner A were blackmailing her.

60. Prisoner A said he had been reading a letter in his cell at about 4.30pm, when the woman came in, sat down and tried to read his letter. He said he got up to turn the volume of his stereo down and she touched his genitals through his trousers as he reached across her. He said he told her to leave the cell and she laughed as she did so. He said he had not encouraged her. He was locked in his cell five minutes later.

61. CCTV footage shows that the woman and Prisoner A went into his cell together at 3.26pm. The subsequent footage was damaged so we cannot establish how long the two spent together in the cell. The footage starts again at 4.32pm when she appears to be checking if he is in his cell. Several minutes later they both briefly went into the cell together. The CCTV also shows that he was locked in his cell at 4.44pm for twenty minutes until association time.

62. Prisoner B said he saw the woman in her cell at about 4.00pm and she was in a panic. She told him that Prisoner A and Prisoner E had wanted to have a threesome with her but it would cost her £2,500.

63. Just before 5.00pm Prisoner B said that the woman gave him a note to pass to officers if anything happened to her. He said he gave the note to an officer that evening, but could not remember which one, and said it had since disappeared. He remembered that she had written in the note that she had had sex with Prisoner E that morning and that the prisoner had kept a tissue with the woman's semen on it to allege that she had raped him. He said that the note also said that Prisoner A and Prisoner E had both discussed having sexual relations with

her and that the two were trying to extort money and a gold bracelet from her. The PO who managed the wing that evening told the investigator that he could not recall a letter or note being handed in by Prisoner B that evening. There is no mention of the letter in either the wing observation book or the woman's case notes. Neither the police nor this investigation found any evidence of the note.

64. Prisoner D said that he saw the woman come from Prisoner A's cell at about 6.00pm. He said she had told him that she had just been having a "fiddle" with him earlier that day, and Prisoner E, and was worried that they were going to set her up by alleging that she had raped them. She was worried that the allegation would affect her prison record, her forthcoming categorisation review and her gender reassignment.

65. At 5.00pm, Prisoner A approached an officer and alleged that the woman had sexually assaulted him. The officer sought advice from the PO about what to do, as he was aware that the prisoner had previously made false allegations. The PO advised the officer to record the incident in the wing observation book, submit a security information report and issue the woman with a notice of a report which he took to the segregation unit for processing. (When prison staff believe a prisoner has broken a Prison Rule, they can place him "on report". The prisoner must be told within 48 hours what they are charged with and, after investigation, a disciplinary hearing, called adjudication, is held. If the charge is proved, the adjudicator imposes a penalty on the prisoner.)

66. The PO spoke to Prisoner A and, in consultation with the duty governor, agreed to move him to the healthcare centre for the night. The woman was locked in her cell until the morning, when the allegation could be investigated. The PO explained that she was not moved to the segregation unit because the allegation had not been proven and the alleged offence was not sufficiently serious. The PO said that he was not aware of any similar accusations being made against her but he understood that the prisoner had frequently moved wings after problems with other prisoners.

67. The PO told the woman that an allegation of sexual assault had been made against her and explained that investigation would continue in the morning. He did not mention Prisoner A's name but thought she knew who had made the allegation. He said that she was angry about the situation. He said he tried to reassure her and suggested that she should not worry too much. This was the last time that he saw her. He said that she was not negative, there was no indication that she was at risk of self-harm and no prisoners raised any concerns about her.

68. The PO did not expect the woman to be charged until the next day, but there were extra officers working late in the segregation unit. An officer gave her a notice of report for sexual assault that evening.

69. After her death, a statement was found in the woman's cell, which appears to be a written response to the charge. In it she said that, on the afternoon of 12 July, having passed Prisoner A a cigarette, he began to masturbate in front of her

behind his cell door and asked her if she would give him oral sex. She said that later that afternoon he invited her into his cell, closed the curtains and door and exposed himself to her again and asked her to perform oral sex on him, but she refused. She said that he then asked about her gold bracelet and what she wanted for it. She told him that the bracelet was not for sale and at the time thought he was joking. She wrote "I now know he wasn't kidding, that he could say anything because only he and I was in the cell". She wrote that she then left the cell and spent the rest of the afternoon talking to other prisoners.

70. The woman was locked in her cell at about 6.00pm, pending investigation of the allegation of sexual assault. Another prisoner on C wing spoke to her through her door. He said that she told him that Prisoner A and Prisoner E had accused her of rape and that they wanted her gold bracelet and money. In a statement to police the prisoner said that during their conversation she "… appeared agitated and annoyed at the accusation", but he did not believe that she would take her own life.

71. Prisoner C said that he also spoke to the woman through her cell door. He said that she was devastated and said that she had been "betrayed" by Prisoner A. She felt foolish and had been blind to think that they were in a relationship. She told him that the allegation against her would be retracted if she agreed to pay him money and give him her gold bracelet. He said that she told him that an SO had told her to "kiss goodbye" to her category being downgraded and her gender reassignment surgery. He said that he had tried to reassure her that the charge had not yet been proven.

72. At about 6.35pm, Prisoner D told the woman that they would deal with the allegations in the morning. He said that she replied by saying, "that she had nothing". He said that she was sitting on her bed at the time and looked up from something she was writing. He said she told him that she was worried that the allegation would stop her gender reassignment and affect her categorisation review and repeated that she "had nothing left". He said that he told her to keep her chin up but described her as "vacant". He told the investigator that he understood that both Prisoner A and Prisoner E were having sexual relations with other prisoners, sometimes for money or medication. He said that this was an easy way for younger prisoners to take advantage of older prisoners to get extra things. He said that officers knew what happened but did not challenge it.

73. Prisoner A told the police that he was not in a relationship with the woman and did not associate with her. He said he was aware of the rumours that he had asked her for jewellery and cash, but denied blackmailing her.

**Evening of the incident**

74. An Operational Support Grade (OSG) and an officer were on duty on C wing on the evening of 12 July. When she came on duty, the OSG was told that the woman had been placed on report for an alleged sexual assault. The officer said he could not remember whether she had been mentioned during the handover with day staff but recalled reading about the allegations in the wing observation

book.

75. At about 9.00pm, when carrying out a regular check of the wing, the OSG heard the woman vomiting in her cell. The OSG asked if she was okay. She had told her she was fine, and only being sick because she had eaten too many biscuits. The OSG said that the woman chatted for a few minutes and assured her that she was okay. The OSG said she had asked if she needed to see someone from healthcare, but she insisted she was fine. The OSG said she encouraged her to use her cell bell if she needed anything. The OSG said that she gave her no indication that anything was amiss, and they did not discuss the sexual assault allegation.

76. At 10.55pm the OSG completed a scheduled check of category A prisoners. As she shone her torch into the cell, she saw the woman in a sitting position in front of the cell window. The OSG banged on the cell door and called out her name, but there was no response. The OSG could not use her radio because the battery had just gone flat, so she returned to the wing office to tell the officer there was a code blue and she needed the cell key. (A code blue is an emergency code used when someone has stopped breathing and requires urgent medical assistance.)

77. The officer returned to the woman's cell with the OSG. When he looked through the observation panel, he saw a ligature from her neck attached to the cell window. He said he called a code blue on his radio at 10.57pm and sought permission to enter the cell from the manager in charge of the prison at night. Authority was given by the PO 20 seconds later. While he was waiting for permission, he broke into his emergency cell key pouch, which he said took 45 seconds, and the officers then went into the cell.

78. The officer took the woman's weight while the OSG cut the ligature made of a boot lace wrapped around a piece of bed sheet, but left it around her neck. They laid her on her back and, when he could not find a pulse, the officer started cardiopulmonary resuscitation (CPR). He was relieved shortly after by the OSG, who continued to give her CPR. The officers described her as cold to the touch but did not believe that rigor mortis had set in.

79. A SO was the third member of staff to arrive at the cell, minutes after the alarm was raised. He said he was met by the officer. He said that when he saw the OSG giving CPR, he returned to the wing office, several feet away and called the communications room, and requested that an ambulance be called immediately. An ambulance was called at 11.04pm.

80. A nurse told the investigator that he had no keys so he was being escorted by the PO to attend to a prisoner on another wing when he heard the code blue at 10.57pm. He said that he and the PO immediately returned to healthcare to collect emergency equipment before going to C wing arriving where they arrived at about 11.05pm. He said it took two or three minutes to return to healthcare and another two or three minutes before they arrived at the cell on C wing.

81. When he got to the cell, the nurse examined the woman but could not find a pulse or any other signs of life. He described her as cyanosed (bluish) and cold to the touch. He took over CPR from the OSG, applied the defibrillator, but it advised not to shock. He continued to administer CPR until about 11.20pm. He said he could not remember whether the ligature was still around her neck when he examined her. Paramedics arrived at the scene at 11.27pm, and pronounced death at 11.32pm. In the ambulance record, paramedics reported that a cord was still around her neck when they examined her.

82. After her death, a letter was found in the woman's cell addressed to her mother and father, in which she set out why she had decided to take her life. She said the allegations against her were "pure lies," that other prisoners would always group together to ensure that she remained in prison and that she lived with hate every day from prisoners and staff.

83. Prisoner D told the investigator that he saw Prisoner A in the healthcare centre (where he worked as cleaner) the next day. He said that Prisoner A told him that he had not meant the woman to kill herself.

84. In a letter to this office, a prisoner said that on the afternoon of 13 July he had talked to another C wing prisoner in the exercise yard. He said that this prisoner did not like the woman and told him that he, Prisoner A and Prisoner E had planned to blackmail her by accusing her of rape to get her gold bracelet and money. However, he had decided not to go ahead with the plan.

**Family Liaison**

85. The woman's parents lived in the south of England and, because of the distance from the prison, were informed of her death by the local police in the early hours of the following morning. Later that afternoon an officer and a PO visited them at their home to explain what had happened and to offer the prison's support. On 2 August, they represented the prison at the funeral. Full Sutton made a contribution of £1,500.00 towards the funeral costs. On 9 August, the woman's parents visited Full Sutton and attended a memorial service with prisoners who knew their daughter. A collection was made by prisoners on the woman's wing and this was forwarded to her family.

## ISSUES

### Support for the woman as a transsexual

86. The woman had been living as a transsexual prisoner for nine months before her death at Full Sutton. In October 2011, she began the first stage of the process, living as a woman for two years, which she hoped would lead to her full gender reassignment. During the investigation into her death the investigators took into consideration the actions taken by staff at Full Sutton with regard to their dealings with her and the requirements of PSI 07/2011 The Care and Management of Transsexual Prisoners.

87. The woman wore women's clothing, had access to make up and the majority of staff referred to her as a female. She met the prison's diversity officer weekly, but did not formally meet either of her assigned personal officers to discuss her gender reassignment in line with the PSI. (We comment on the adequacy of her personal officer support later in the report.) The clinical reviewer reports that her gender dysphoria was treated appropriately by healthcare staff. He finds that she received sufficiently regular support from the prison's healthcare team, in particular by the mental health in-reach and psychology teams.

### The woman's state of mind on the day of the incident

88. In a statement, found after her death, the woman said she had refused Prisoner A's sexual advances, but in hindsight noted that being alone in his cell with him meant that he could say anything. At the time of her death her category A status was under review. The Director of High Security had rejected two previous recommendations for her security category to be reduced to category B. She was concerned that her categorisation inhibited her sentence progression and her hopes of gender reassignment. She told other prisoners that she was worried that the allegation had put both these things at risk.

89. The woman had been informed in the early evening of 12 July that allegations of a sexual assault had been made against her. Once the allegation was made, she was locked into her cell and charged with an offence under Prison Rules. Removing her from association with other prisoners and locking her into her cell appears to have amounted to segregation. PSI 47-2011 which covers prison discipline procedures says "If there is a significant risk of collusion or intimidation in the period between laying the charge and the governor's initial determination at the opening of the hearing whether to refer the case to an independent adjudicator, the accused prisoner may be segregated under Prison Rule 53 (4). An initial Health Screen is to be completed and taken into account". Segregation has to be authorised by the duty governor or operational manager once the initial health screen had been considered.

90. The prison considered segregating the woman, as noted in the wing observation book, but did not do so because the alleged offence was not sufficiently serious and we understand because of a movement of prisoners into the prison's segregation unit. However, we think this was a serious offence and it had

serious implications for her. While we understand the reasons it was decided that it would be appropriate at that stage to keep her apart from other prisoners, we are concerned that she was locked in her cell as an informal and ad hoc arrangement without the safeguards that would have applied to a formal decision to segregate. This would have included senior managerial authorisation and a health screen which would have allowed her the opportunity to discuss her state of mind and for an agreed level of observations to be set. As a safeguard, we consider that this process should take place wherever a prisoner is segregated, whether or not the prisoner is held in the segregation unit.

**The Governor should ensure that all decisions to segregate prisoners comply with Prison Service instructions, wherever the segregation takes place.**

## Personal officers

91. Officers knew that the woman was very anxious about her gender reassignment and how much she wanted to be re-categorised. Although there were rumours circulating on the wing about prisoners blackmailing her, officers were either unaware of them or chose to ignore them. There is also little evidence that there was any recognition that she was particularly vulnerable at that time. We would have expected a personal officer to provide particular support. An effective personal officer scheme requires regular meaningful interaction, which should give additional insight into prisoners' relationships and should be more possible to achieve in a prison such as Full Sutton with a stable, long term population.

92. PSI 7/2011 requires personal officers to meet monthly with prisoners going through gender reassignment. There is no evidence of such a meeting in the woman's records. An officer was appointed as an additional personal officer when she moved to C wing because of her "special circumstances" (gender reassignment), but never made an entry in her case history notes. It is a concern that her other personal officer did not make an entry in her case history notes for four months, between the end of November 2011, when she first introduced herself and March 2012.

93. This does not suggest that an effective and supportive relationship had been established which would have allowed either personal officer to have identified any specific concerns that the woman had. The last personal officer entry in her case history notes was on 18 June, one month before her death.

**The Governor should ensure that personal officers have regular, quality contact with the prisoners allocated to them and that they record their interactions on P-Nomis case histories provide appropriate support for prisoners with particular needs.**

## Monitoring relationships on C wing

94. The Governor explained that there are two officers for every 18 prisoners during the day and 14 officers on C wing while prisoners are out of their cells in the

evening. Such a level of staff should result in a good awareness about what happens on the wing. Prisoners are allowed to have their doors unlocked on C wing and trusted to associate in their cells. Such an approach relies on officers being visible on the wing, patrolling and interacting with prisoners and recording their interactions.

95. During interviews, most officers said they were not aware of any sexual activity or relationships between prisoners on C wing. Some officers acknowledged that relationships of a sexual nature did take place between prisoners. A PO said that he was aware that sexual grooming on the wing took place and would expect staff to challenge it when it happened. The Diversity and Equality Manager commented that officers tended to focus on the predatory behaviour of older prisoners.

96. As the woman was convicted of raping another prisoner, she was also a potential risk to other prisoners. She was also vulnerable to sexual coercion and potential grooming herself and it was alleged that younger prisoners had attempted to blackmail her. The investigator reviewed the security records of several prisoners on C wing. There was evidence that older prisoners were being taken advantage of by younger prisoners, for example giving sexual favours in return for medication or money.

97. Awareness of relationships on the wing differed between staff. The Diversity Manager told the investigators that staff would, "… have more of an idea if there's an argument going on but not so much if there's a relationship going on." A SO said that, although she heard rumours, she had never dealt directly with prisoners involved in sexually grooming. The senior officers said that no prisoner had complained about being groomed, although this is not likely, given the process of grooming. Another SO said that sexual relations were something that, although not spoken about much, obviously took place. He said:

> "… if somebody had made a report and that they got back to me regarding what had allegedly taken place with the woman and Prisoner A then I wouldn't have thought it was anything out of the ordinary really from what I'd heard or what I've known previously about her."

The SO told the investigators:

> "I think one of the problems that you've got is it's a very, very difficult subject to approach. I think unless you physically actually see something taking place in front of you it's very difficult to challenge. I would think for the average officer on the wing it could be quite difficult … I think there's that stigma attached to thinking, well, what happens if I do challenge someone and I get it wrong or if they put a report in against me and how would that sort of affect me, you know I don't want to come across as being a homophobic. It's very, very difficult that."

98. At the last inspection the Inspectorate was positive about the security department's approach to disseminating information and managing risk. The

Acting wing manager told the investigator that the security department called him with intelligence about prisoners on the wing and he briefed officers at the morning meeting and wrote information in the wing observation book, which all staff should consult. He said that he would expect officers to challenge unwarranted sexual attention between prisoners, but he had never come across such behaviour.

99. Prisoner A, Prisoner E and the woman's security records all showed a history of inappropriate interactions with other prisoners, yet most officers claimed not to know these prisoners' history, and therefore could not effectively manage their risk. We are surprised that, on a wing with a number of prisoners convicted of sex offences, there was so little apparent knowledge among the staff about prisoners' offences and how this might relate to their behaviour in prison and provide information about their risk. During interviews, it was apparent that many members of staff, including senior officers, were not aware that the woman had been convicted of rape in prison. A wing manager confirmed that most officers on C wing were not aware of prisoners' offences.

100. Although there was security information about sexual activity on the wing, staff had little knowledge of it, even to the extent that a SO said he had never come across unwarranted sexual attention between prisoners. This contrasts with the accounts some prisoners gave the investigator. This suggests either that officers tended to turn a blind eye to sexual activity among prisoners or that they were not sufficiently vigilant to what was happening on the wing.

101. The Diversity Manager said that he had introduced a training programme provided by the Grimsby Institute to improve staff's understanding of sexuality and gender identity issues. He said that awareness sessions had been introduced and that the aim was to introduce the issues to all staff by the end of the year.

102. Sexual activity inevitably occurs in prison but is usually hidden from view. Staff need to have access to any relevant information and be vigilant about identifying, and encouraged to challenge, inappropriate sexual behaviour.

**The Governor should ensure that all wing staff are aware of prisoners' offences and how this affects the management of their risk on the wing.**

**The Governor should ensure that wing staff receive all relevant security information, effectively patrol, monitor and interact with prisoners on the wing and challenge any inappropriate sexual behaviour.**

## Cell key pouch

103. While waiting for permission to enter the woman's cell, the officer attempted to break the plastic seal on the pouch containing his emergency cell key, but it took nearly a minute. We are concerned at the length of time that it took for the officers to break into the emergency key pouch.

104. Entering a cell in an emergency is a rare and often stressful situation, and the plastic seals can be quite difficult to break when officers are unused to doing so. The OSG and the officer both said it would be useful for night staff to practice breaking the plastic seal on the emergency key pouch to avoid a similar delay in the future. Using the anti-ligature knife which all officers should carry is an effective way of cutting through the plastic seal quickly. We make the following recommendation:

**The Governor should ensure that night staff are practiced and confident in opening emergency cell key pouches.**

**Access and location of emergency response equipment**

105. There is one nurse in Full Sutton at night, based in the healthcare unit. The night nurse does not have keys and has to be escorted by an officer if there is an emergency on the wing. When the officer called the code blue, the nurse was on his way to another area of the prison. As there was only one emergency grab bag, the nurse had return to healthcare unit to collect the emergency resuscitation response bag before going to C wing, which took about two minutes to the response.

106. Prison Service Instruction (PSI) 64/2011, which covers emergency response, requires that:

> "*Emergency Response Kits must be available in all residential areas. Prisons, in consultation with their healthcare provider, must determine what items need to be included in them.* It is good practice to also have emergency Response Kits in non-residential areas, based on a local risk assessment."

107. In his clinical review the clinical reviewer says:

> "Although the code blue response time may have been reduced had an emergency resuscitation kit been available on the wing I do not believe that it would have significantly improved the chances of a positive outcome in this case."

108. The clinical reviewer says that future code blue response times could be improved if emergency resuscitation equipment is located in residential areas and is accessible by prison staff. Prisons are required by PSI 64/2011 to have emergency equipment in all residential areas. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that there are emergency response bags in all residential areas.**

## Resuscitation

109. When the woman was found the officer and and OSG appropriately began CPR. When the nurse arrived he took over CPR and continued for twenty minutes, but stopped shortly before the arrival of paramedics. The clinical reviewer considers the nurse's decision to discontinue CPR before the arrival of the paramedics was appropriate, because there was no change in the woman's condition.

110. When the paramedics arrived they confirmed that the woman had died, but noted that a cord was still tight around her neck. The nurse told the investigator that he could not recall whether or not the cord was there when he had administered CPR, but at the time he noted in the medical record that this "… had been cut but remained around her neck".

111. Neither the responding officers nor the nurse removed the ligature from around the woman's neck. In his clinical review the clinical reviewer says:

> "A ligature should always be removed prior to commencement of CPR as it may be constricting the carotid artery and / or the airway, thereby rendering attempts at CPR redundant. In the case of [the woman] the exact degree to which the nurse's delivery of CPR with the ligature still in situ may have impacted upon the resuscitation efforts is difficult to evaluate in this report but, considering the initial 'asystole' reading on the equipment when first connected, the time elapsed since [the woman's] discovery and [her] physical presentation on the nurse's arrival, it is unlikely that [she] would have responded to his resuscitation efforts had the ligature been removed."

112. We agree with the clinical reviewer's findings and make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff are aware of the need to remove ligatures before CPR is attempted.**

**Delay in calling an ambulance**.

113. The code blue was called at 10.57pm, but an ambulance was not requested until 11.04pm. Neither of the officers who found the woman called for an ambulance and it was not until the SO arrived that one was called. While seven minutes may not seem a long delay, any delay in calling an ambulance can have a significant impact on a person's chance of survival in an emergency. It is good practice for an emergency ambulance to be called as soon as there is an emergency code blue.

114. The Director of Offender Health and the Chief Executive Officer of NOMS wrote to all prison Governors and Directors and Heads of Healthcare on 12 February 2011. The letter highlights the importance of calling an ambulance as soon as possible in an emergency. Although the delay in calling an ambulance would not

have changed the outcome for the woman, on another occasion, such a delay could be crucial.

115. We made a similar recommendation in the report into the death of a man at Full Sutton in February 2009. We make the following recommendation:

**The Governor should ensure that an ambulance is requested immediately in an emergency.**

**Payment of funeral expenses**

116. Full Sutton contributed £1,500.00 towards funeral expenses. The total cost of the funeral was £3,903.00.

117. PSI 64/2011 states that the prison must offer to pay a contribution towards reasonable funeral expenses of up to £3,000. Reasonable costs may include funeral directors fees, the hearse, a simple coffin, cremation or burial fees (but not the cost of a burial plot) and Ministers' fees. The prison did not provide a breakdown as to the expenses their contribution covered, but explained that £1,500.00 was a rough average of their contribution for the previous ten deaths in custody. We do not consider that this is an appropriate way to assess reasonable funeral costs which should be based on actual costs paid. On this basis, we are not satisfied that the prison made a reasonable contribution to the cost of the funeral in line with Prison Service guidance.

**The Governor should ensure that, in line with Prison Service guidance, an appropriate contribution is made to cover the family's reasonable funeral costs.**

## RECOMMENDATIONS

1. The Governor should ensure that all decisions to segregate prisoners comply with Prison Service instructions, wherever the segregation takes place.

   **Not Accepted –** *HMP Full Sutton believes the facts around this recommendation to be factually inaccurate. PSO 1700 states that, if a prisoner is excluded form the regime under R53(4) for a period of four hours or more prior to the adjudication, they must undergo the appropriate processes. The woman had been placed into her cell approximately 40 minutes prior to the end of association in order to prevent an incident from escalating. This was not segregation and therefore the process did not need to be followed.*

2. The Governor should ensure that personal officers have regular, quality contact with the prisoners allocated to them and that they record their interactions on P-NOMIS case histories, and provide appropriate support for prisoners with particular needs.

   **Accepted –** *Managers will brief staff to complete two x quality entries per month recording them on NOMIS.*

3. The Governor should ensure that all wing staff are aware of prisoners' offences and how this affects the management of their risk on the wing.

   **Not Accepted –** *All personal officers should have a full understanding of the prisoners for whom they are responsible. However, it would prove extremely difficult to ensure that all staff should be aware of the offences and background of all prisoners.*

4. The Governor should ensure that wing staff received all relevant security information, effectively patrol, monitor and interact with prisoners on the wing and challenge any inappropriate sexual behaviour.

   **Accepted –** *Security intelligence is discussed twice weekly at the residential briefings and passed on to staff via the wing daily briefing. Wing managers will ensure that staff patrol, interact and challenge any inappropriate sexual behaviour.*

5. The Governor should ensure that night staff are practiced and confident in opening emergency cell key pouches.

   **Accepted –** *The practice of opening emergency cell pouches will be incorporated into training.*

6. The Governor and Head of Healthcare should ensure that there are emergency response bags in all residential areas.

   **Not Accepted –** *Emergency response bags will be located in the two key areas ensuring a response for the two main areas of the prison – i.e. healthcare which is*

*close to A-D wings and G wing; F wing which will service E, F and segregation.*

7. The Governor and Head of Healthcare should ensure that staff are aware of the need to remove ligatures before CPR is attempted.

   **Accepted –** *This is a training issue for healthcare staff and night staff. Staff information Notice to be issued.*

8. The Governor should ensure that an ambulance is requested immediately in an emergency.

   **Accepted –** *Instructions to be made available to control room Senior Officer.*

9. The Governor should ensure that, in line with Prison Service guidance, an appropriate contribution is made to cover the family's reasonable costs of her funeral.

   *The prison service responded that each case would be managed on its own merit in line with Prison Service policy.*