

**Investigation into the circumstances surrounding the  
death of a young woman at HMP New Hall  
in May 2006**

**Report by the Prisons and Probation Ombudsman for  
England and Wales**

**May 2007**

This is the report of an investigation into the death of a young woman in May 2006 at HMP New Hall. She was found hanging in the toilet area of her shared dormitory. She was just 22 years old.

I wish to offer my sincere condolences to the young woman's family and friends for their sad loss.

The investigation was conducted by two of my investigators. I would like to extend my thanks to the Governor and her staff at New Hall for their help and co-operation throughout this investigation.

A clinical review was undertaken by the relevant Primary Care Trust into the medical care that the young woman received while in custody. I am grateful to the clinical reviewer for his timely and comprehensive report. Indeed, it has meant that my own report can be abbreviated given that so much is covered in the clinical review. All the more so, given that the young woman had offered no indication either to staff or to fellow prisoners that she might be considering harming herself.

I understand that, despite her young age, the young woman had already spent eight previous periods at New Hall. On each occasion, she had undergone detoxification from drug abuse. Her offences all seem to have involved acquisitive crime to fund her drug habit.

This pattern is characteristic of very many women prisoners I have met at New Hall, Styal, Holloway, and elsewhere. Their offending should not be trivialised as it has real victims. And its repeated nature seems to leave the courts feeling they have few alternatives but to impose custodial remands or short sentences of imprisonment. Nevertheless, the women themselves are amongst the most vulnerable in our society, and the crimes they commit are manifestly at the less serious end of the spectrum. They are the group of prisoners for whom the rather old fashioned term 'diversion from custody' really should have some meaning.

I make four recommendations.

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**Prisons and Probation Ombudsman**

**May 2007**

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## **SUMMARY**

The young woman arrived at HMP New Hall on 8 April 2006. She was medically assessed during the reception process and placed into the Substance Misuse Unit where she began a methadone detoxification programme.

The time she spent on the unit passed without incident. However, on 18 April, the young woman asked in a written note not to be moved to E wing when she completed her detox. She wrote that she had had some trouble outside of prison with two of the women on E wing. When she was eventually discharged from the Substance Misuse Unit on 28 April, she was moved to Residential block 1.

The young woman shared a two roomed dormitory with three other women. It appears that she settled in well and was liked by her room mates.

Just after 1 am on 1 May, one of the young woman's room mates found her hanging in the toilet area. She was suspended by a bed sheet ligature from a water pipe over the sink. The cell bell was rung and officers responded swiftly.

Staff entered the dormitory and she was cut down. Cardio pulmonary resuscitation was commenced immediately. A defibrillator was attached to the young woman but it indicated not to shock. Paramedics arrived and took over the resuscitation attempt, but pronounced her dead at 2.10 am.

The young woman had given no indication, either to staff or to her fellow prisoners, of any thoughts about self harm or suicide. In fact, she was annoyed that the police had ticked the self harm box on the Prisoner Escort Record, saying 'it shouldn't be on the paperwork, I've done nothing'.

## **THE INVESTIGATION PROCESS**

1. The investigation was opened by two of my investigators. The Governor and her staff produced the young woman's medical record and a large number of other documents for examination. Notices were distributed around the establishment, notifying staff and prisoners of the investigation. A number of prison staff and prisoners were subsequently interviewed.
2. My investigators liaised with the police officers investigating the death on behalf of Her Majesty's Coroner. They confirmed that they were treating the death as a probable suicide and had ruled out the involvement of anyone else. My investigators were given copies of the police statements to assist with my investigation.
3. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation. Upon completion, this report will be sent to the Coroner to assist with his enquiries into the young woman's death.
4. One of my Family Liaison Officers contacted the young woman's mother to inform her of my investigation. Her mother said that she was happy with the contact she had had with the prison. She also said that she would wait to read our draft report before meeting with a member of my team.
5. In line with our standard procedures, the Primary Care Trust (PCT) was informed of the woman's death. A clinical review was undertaken, looking into the medical treatment and care received by the young woman whilst at New Hall.

## **HMP NEW HALL**

6. HMP New Hall is a closed female prison holding adults, young offenders and young people. There is also a 40 bed semi-open unit for adult women.
7. A dedicated safer custody team has been set up to drive forward the Safer Prisons agenda. The strategy has been to adopt a 'whole prison approach', to the management of those prisoners identified as being at risk of suicide or self harm. This work includes a multi-disciplinary Substance Misuse Unit (SMU), which provides stabilisation and maintenance through clinical interventions, heat therapy, auricular acupuncture and a 'Return to Fitness' programme.
8. New Hall also runs enrichment activities, designed to enhance self-esteem, such as hand pampering and nail art, as well as offending behaviour programmes, educational and work opportunities.
9. The prison's healthcare provision is split between general primary healthcare run by the PCT and the SMU which is run by another PCT.
10. There have been six previous deaths at New Hall since I assumed the responsibility for investigating all prison deaths in April 2004. Five of those deaths were apparently self inflicted, although the circumstances and issues were not directly equivalent to those raised by the death of the young woman who is the subject of this report.

## KEY EVENTS

11. The woman was remanded to New Hall on Saturday 8 April 2006, having been arrested for theft the previous day.
12. A nurse saw the young woman during the reception process and completed a First Reception Health Screen form. She noted that the Prisoner Escort Record (PER), completed at Queens Gardens Police station the previous day, had a tick in the box marked 'suicide/self-harm'. When the reception nurse asked the young woman about that, she replied, 'It shouldn't be on the paperwork, I've done nothing'. The nurse wrote, 'behaviour appropriate – withdrawing from drugs', on the health screen form. During interview she said that she had no concerns about her having thoughts of self-harm. She said that was based on what the young woman had said in answer to her questions, the way the young woman presented herself and her own training and experience.
13. The young woman said that she was using £100 worth of heroin and 'crack' a day, and that she had last used the drugs during the previous day. She told the nurse that she felt that she was withdrawing and wanted counselling in relation to her drug abuse.
14. The nurse ticked the boxes on the health screen form for the young woman to be referred to the Detox Unit (meaning the SMU) and the CARATS team, and for her to be admitted to the Detox Unit. (CARATS (Counselling, Assessment, Referral, Advice, and Throughcare Services) work within the prison and can provide one to one counselling, ongoing care and support plans and links with external treatment services in preparation for release.)
15. The young woman was admitted to the SMU and started on a methadone detoxification, beginning with a seven day stabilisation programme. It was noted in her medical record that, during her first night, she was screaming in her sleep sounding very distressed, although she did not wake.
16. The following few days passed without incident. On 14 April, an entry was made in her history booklet stating, '[The young woman] keeps her head down and gets on with things, is no problem on the wing.' (History sheets are used to record noteworthy events relating to a prisoner's time in custody.)
17. On 15 April, the computer record does not show a dosage of methadone being dispensed to the young woman, although the administration record chart for that day shows 25 mg of methadone was issued to her. The clinical reviewer having discussed the matter with a number of staff was satisfied that the reason for there not being an entry on the computer system was that some of the staff were unfamiliar with the new 'Methasoft' system.
18. In response to the issue of our draft report the prison have replied that the clinical SMU staff were trained in the use of the 'Methasoft' software in March 2006 and that a systems failure was the reason for the lack of an entry.

19. The young woman wrote a request on 18 April asking not to be moved onto E wing when her time on the SMU finished. The reason she gave was that she had had some trouble outside of prison with two women who were now on E wing. She believed that she would get into fights.
20. On 24 April, the young woman was given a reward slip for always being polite and no trouble on the wing. It was attached to her file.
21. On 28 April, the young woman was moved to Residential block 1 and housed in dormitory 1, room 2. This was a multi-bedded cell, consisting of two rooms and a toilet area. She shared the cell with three other women. A note on her history sheet states that '[the young woman] has been on Res 1 before; she knows what happens and is happy to be on the unit.'
22. As noted, the SMU is managed by the Primary Care Trust and the general prison healthcare facility by another Primary Care Trust. When the young woman moved from the SMU, there was no clinical handover evident in her medical record, although as highlighted in the clinical review there was a continuity of care plan put in place by the CARATS team. The lack of clinical handover was mentioned by one of the other women who shared the dormitory with the young woman. This issue will be addressed by the phased introduction of the Integrated Drug Treatment System (IDTS) which began in July 2006.
23. According to the young woman's cell mates, she was happy to be in the dormitory with them. Neither they, nor the staff, saw any indications of her intention to self harm.
24. During the evening of Sunday 30 April, the young woman was apparently in good spirits. She sat and watched television and smoked with the others. One of her cellmates said that she woke up twice during the night. The first time she saw the young woman lying on the bottom of a set of bunk beds, not her own bed. On the second occasion, the young woman was getting herself a bowl of cereal. Her cellmate did not speak to her on either occasion and she does not think the young woman noticed her being awake.
25. About 1 am on Monday 1 May, the second cellmate woke the third cellmate, who was snoring loudly. The third cellmate got out of bed and went into the toilet area. There she saw the young woman hanging by a ligature, fashioned from a green prison-issue bed sheet. The ligature was attached to the water pipe above the sink. She walked back into the sleeping area and said, '[third cellmates name] It's [the young woman], she's done something stupid and is hanging.'
26. The second cellmate pressed the cell bell to summon help. Two officers went to answer the bell and the assist Night Orderly Officer followed close behind, as cell bells were unusual during the night. The Night Orderly Officer radioed for further assistance as she made her way to the dormitory, but halfway through her transmission the radio battery ran out of power. Luckily, the nurse in healthcare had heard the part message and made her way to the dormitory.

27. The assist Night Orderly Officer opened the cell with her key, the officers and the Night Orderly Officer, who had joined them, entered the cell. The Night Orderly Officer immediately lifted the young woman to relieve the pressure on her neck, with assistance from a third officer who had just arrived. One of the initial attending officers cut through the ligature with a 'fish knife' (a specially supplied safety knife used to cut ligatures). The young woman was lowered to the floor and the third officer then used his knife to cut the sheet from around the young woman's neck.
28. The assist Night Orderly Officer had left the dormitory to call for an ambulance. She returned to the centre office and rang the control room. When they answered she was put through to the ambulance control room. As the call was not answered immediately, she passed the phone to another officer who was in the centre office. The ambulance was requested at 1.12 am according to the clock in the control room. The ambulance service logged the call as being received at 1.25 am.
29. A nurse arrived at the dormitory as the young woman was being cut down and asked for her to be moved out of the toilet area to give her more room to work. She and one of the initial attending officers began cardio pulmonary resuscitation (CPR) whilst the Health Care Assistant (HCA) was called to bring the resuscitation bag from healthcare. The nurse noted that the young woman's pupils were fixed and dilated and she could not detect a pulse.
30. The HCA arrived shortly after with the equipment and the nurse attached a defibrillator to the young woman. It indicated 'no shock', so she continued CPR now using the 'ambubag' to supply oxygen.
31. The paramedics are noted to have arrived at the dormitory at 1.46 am. CPR continued until 2.10 am, when they pronounced the young woman dead.
32. At 3.45 am, the prison chaplain telephoned the woman's mother and informed her of her daughter's death. Her mother was not at home and the chaplain was given the mobile number to reach her.
33. At 4 am, the staff involved were brought together for a 'hot debrief', to discuss the response and handling of the situation. Two issues were raised. The first was that there was not a key available in the sealed pouch to enter the young woman's dormitory cell. However, as the assist Night Orderly Officer was present on the wing with the keys it caused no delay. (My investigators were informed during their investigation that the key issue has now been rectified, with a key available should it be needed in the future.) The second issue was that staff found that the papers in the Death in Custody Contingency Plans lacked a check list and that there were multiple copies of some papers.
34. Staff were generally happy with the way the establishment took care of them after the young woman's death. However, the assist Night Orderly Officer thought it insensitive that on her first two shifts back at work she was assigned

a 'special watch' (watching a prisoner at risk of self harm). After she raised the issue, she was reassigned for the first shift.

35. The young woman's mother has said that she was very happy with the way the prison has handled her daughter's death and felt that the news was broken to her sensitively. She has visited the prison and spoken with some of the officers who tried to resuscitate her daughter. The establishment paid for her daughter's funeral. The young woman's mother is now a regular visitor at the prison, speaking with other prisoners to give them support.
36. During the investigation it was established that some entries on the young woman's paperwork relating to previous self harm attempts were incorrect. They had been entered in error, instead of in the records of another prisoner with a similar name. As noted in the clinical review, the prison acted swiftly to remove the entries, provide staff training and ensure systems were put into place to lessen the possibility of further human errors.
37. The three women with whom the young woman shared the dormitory were all very complimentary about the staff at New Hall. Neither they nor any of the staff who had any contact with the young woman throughout her time at New Hall saw any signs to indicate that she was likely to self harm, let alone take her own life.

## **ISSUES**

38. There was no indication that the young woman was contemplating taking her own life or harming herself. When she was found hanging and the alarm raised, the staff reacted swiftly and professionally. However, as noted, there were a few problems although, through luck and fortunate staff location, they did not cause delay or hindrance to the response in this case.

### ***Family notification***

39. Best practice is for the sad news of a death in custody to be broken to the next of kin in person by a representative of the prison or, in certain circumstances, by the police. In this case, the young woman's mother was telephoned by the prison chaplain, and in fact it was then established that she was away from home. A mobile number was given to the chaplain who was then able to make contact and break the news.
40. The chaplain offered the young woman's mother a personal visit, but she decided to visit the prison herself the next day. My investigator has spoken to the Governor who made the decision to telephone the young woman's mother. Her decision was based on the time of day and the concern to let her know of her daughter's death before the news broke in the media.
41. I am entirely satisfied that in this instance the decision about how to contact the next of kin was taken for the right reasons, and I note that the young woman's mother felt she was told of her daughter's death in a sympathetic manner. However, in these tragic and unenviable circumstances, all prisons should aim to notify next of kin in person wherever this is possible.

### ***Radio batteries***

42. When the Night Orderly Officer used her radio to summon medical assistance, the battery died a few seconds into her transmission. The officer in the control room had heard the part message and had telephoned to the healthcare unit to pass on the request. The nurse had also heard the part message and in fact arrived as the young woman was being cut down. I believe the nurse was entirely right to make her way directly to dormitory 1, although if the radio transmission had been completed she would have been able to arrive with the resuscitation bag rather than having to send for it.
43. Radios that are working properly are especially important during the night time lock-down, because of the reduced staffing levels and difficulty in moving around the prison.
44. Faulty or poorly charged radio batteries have been mentioned in a number of my investigations. Poor recharging practice and use of batteries beyond their useful life have previously been cited as the causes of radio failure.

**The Governor should consider an investigation into the quality of the establishment's battery stock and consider whether any additional staff training into battery charging and rotation procedures is required.**

***Methasoft computer system***

45. On 15 April, according to the computer records, the young woman did not receive her dosage of methadone. Yet the paper records confirm that she did in fact receive her medication. The clinical reviewer identified during conversation with staff that not all of the SMU staff were fully conversant with the computerised 'Methasoft' system.

**The prison health partnership should ensure that all relevant SMU staff are trained in the use of the 'Methasoft' computer system.**

***Cell Keys***

46. It was discovered during the investigation that the staff assigned to Residential 1 did not have a key to the dormitories available to them in their sealed pouches. In this particular instance, the assist Night Orderly Officer was on the wing and able to use the key that she carried. However, having to rely on the close proximity of certain staff to a location is clearly not ideal.
47. Although my investigators were told that a key is now available, I would like the new arrangement formalised in the local arrangements for patrol periods, including night state.

**The Governor should ensure the arrangements for accessing rooms are included in the written arrangements for patrol periods.**

***Death in custody contingency plan***

48. During the 'hot debrief', it came to light that the death in custody contingency plan contained multiple copies of some papers and no check list, making compliance less straightforward than it should be.

**The Governor should review the death in custody contingency plans and associated documentation, to ensure they are fit for purpose.**

## **RECOMMENDATIONS**

- **The Governor should consider an investigation into the quality of the establishment's battery stock and consider whether any additional staff training into battery charging and rotation procedures is required.**
  
- **The prison health partnership should ensure that all relevant SMU staff are trained in the use of the 'Methasoft' computer system.**
  
- **The Governor should ensure the arrangements for accessing rooms are included in the written arrangements for patrol periods.**
  
- **The Governor should review the death in custody contingency plans and associated documentation, to ensure they are fit for purpose.**