Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Ms Karen Williamson, a prisoner at HMP Peterborough, on 8 April 2019

A report by the Prisons and Probation Ombudsman

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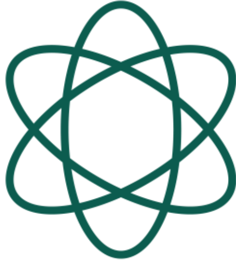
Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

OGL

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Karen Williamson died in hospital on 8 April 2019, after being found hanging in her cell in the segregation unit at HMP Peterborough on 3 April. Ms Williamson was 53 years old. I offer my condolences to Ms Williamson's family and friends.

Ms Williamson had been diagnosed with an emotionally unstable personality disorder. She had a long history of drug misuse, self-harm and volatile and impulsive behaviour. She arrived at Peterborough on the afternoon of 28 March, after taking a member of staff hostage in HMP Send that morning. She became violent in reception and was located in the segregation unit. Shortly after arriving there, she cut herself. Staff began to monitor her under Prison Service procedures to manage those at risk of suicide and self-harm (known as ACCT).

I am concerned that staff underestimated Ms Williamson's risk to herself, and that her risk was not reviewed in the light of a potential attempt to tie a noose on 2 April. I consider that, as a result, her observation levels were reduced prematurely.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2020**

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Summary

Events

1. Ms Karen Williamson was sentenced to life imprisonment in 2011 for murder. She had been diagnosed with an emotionally unstable personality disorder and had a long history of self-harm, including several apparent suicide attempts, of drug misuse, and of volatile and impulsive behaviour.

2. In 2018, Ms Williamson applied for a place in a unit at HMP Send for prisoners with a personality disorder. She was moved to Send on a trial basis in March 2019, but she did not settle well and was judged unsuitable for the unit.

3. On the morning of 28 March, Ms Williamson took a member of staff hostage, armed with a pair of scissors. The situation was soon brought under control but it was decided that Ms Williamson should be transferred out of the prison urgently. HMP Peterborough reluctantly agreed to take her after other prisons had refused, and she was transferred to Peterborough that afternoon.

4. Ms Williamson became violent when she arrived at Peterborough, and had to be restrained. She was taken to the segregation unit. Shortly after arriving there, she threatened to harm herself and made a cut to her arm. Staff opened suicide and self-harm prevention procedures (known as ACCT). Managers concluded that she could not be held safely elsewhere in the prison so she remained in the segregation unit under constant observation.

5. Over the next few days, Ms Williamson's mood varied, with occasional outbursts against staff. She said that she did not want to be in Peterborough (which had distressing associations for her). Staff told her that they were seeking a transfer to another prison for her. She remained under constant observation until 1 April, when her observations were reduced to four per hour.

6. On the morning of 2 April, a prison officer checked on Ms Williamson and found her standing on a bin, tying a piece of fabric to her doorframe. The officer talked to Ms Williamson, informed a colleague, and made a note in Ms Williamson's ACCT document. Ms Williamson's mood fluctuated throughout the morning. In the afternoon a multi-disciplinary meeting, which did not know about the incident in the morning, decided to move her to a standard wing at Peterborough as soon as a place became available.

7. The next day, Ms Williamson declined breakfast, was rude to a nurse during the medication round, and became agitated during a chaplaincy visit. At an ACCT review that morning, she denied any thoughts of wanting to harm herself and her observations were reduced to two per hour. At lunchtime, Ms Williamson refused to collect her meal when told to remove her dressing gown.

8. At 3.42pm a prison officer went to carry out an ACCT check. Ms Williamson called out that she was using the toilet. When the officer returned at 4.01pm, Ms Williamson was lying on the cell floor with a noose around her neck. Officers went into the cell, removed the ligature and provided medical assistance. They were quickly joined by nurses. They continued to try to resuscitate Ms Williamson until ambulance paramedics arrived and transferred Ms Williamson to hospital.

9. Ms Williamson remained on life support in hospital until 8 April, when the support was withdrawn. She died that evening.

Findings

Ms Williamson's location

10. We accept that Ms Williamson had to be moved out of Send after she took a member of staff hostage. Peterborough was not the ideal location as it had unhappy associations for her. However, Ms Williamson was told that staff were trying to arrange her transfer to another prison and we are satisfied that she was expecting to be moved before long. (In fact, this was not the case but Ms Williamson did not know that when she hanged herself.)

Segregation

11. Prisoners under ACCT management should only be segregated in exceptional circumstances.

12. Ms Williamson arrived at Peterborough as a result of a very serious incident at Send and was located in the segregation unit after she became violent when she arrived at Peterborough. We are satisfied that other locations were considered and that the decision to keep Ms Williamson in the segregation unit was not unreasonable in the circumstances. We are also satisfied that the prison intended to transfer her to a standard wing as soon as possible and that Ms Williamson was told this on 2 April.

13. In line with Prison Service policy, Ms Williamson was seen by healthcare staff, by a member of the chaplaincy, and by a senior manager every day, and she was given a radio and in-cell hobby materials to help keep her occupied.

Risk assessment

14. ACCT procedures were correctly opened shortly after Ms Williamson arrived at Peterborough.

15. However, the incident on 2 April (when Ms Williamson was seen making a possible attempt to tie a noose) should have triggered a review of her risk level. We are very concerned that this did not happen and that decisions were made at the complex needs meeting that afternoon and at the ACCT review on 3 April without anyone knowing about the incident.

16. We are also concerned that it appears no one read the ACCT ongoing record before the ACCT review on 3 April at which Ms Williamson's observations were reduced further. Even without knowledge of the incident on 2 April, we consider that the decision to reduce Ms Williamson's level of observations on 3 April was premature and appears to have been based on her presentation at the review, rather than consideration of her ongoing risk factors.

Access to craft materials

17. Ms Williamson was given craft materials to keep herself occupied and used a piece of ribbon from this to hang herself. We are concerned that her access to these materials was not risk assessed, particularly after the incident on 2 April.

Bullying

18. A friend of Ms Williamson's alleged that Ms Williamson was being bullied by staff before she hanged herself. We cannot rule out the possibility that Ms Williamson was being bullied by staff, but we have found no evidence that this was happening.

19. We are satisfied that the prison responded appropriately to the allegation by conducting a prompt internal investigation.

Healthcare

20. The clinical reviewer had no concerns about the healthcare provided to Ms Williamson before she transferred to Peterborough on 28 March. She was, however, concerned that staff did not give sufficient weight in their risk assessments to the behaviours associated with Ms Williamson's personality disorder.

Substance misuse

21. We are satisfied that Ms Williamson was not under the influence of illicit or illicitly traded drugs when she hanged herself.

Emergency response

22. When staff found Ms Williamson unconscious, the response was appropriate. They entered the cell without delay, and medical staff attended promptly. Once Ms Williamson transferred to hospital, the prison contacted her mother and arranged for her to attend the hospital.

23. The template used for the hot de-brief with staff is an example of good practice.

Recommendations

- The Director should ensure that staff appropriately escalate important information relating to prisoners under ACCT management.
- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that evidence of risk is fully considered and balanced against how the prisoner presents herself.
- The Director should ensure that case managers familiarise themselves with recent events before holding ACCT reviews.
- The Head of Healthcare should ensure that healthcare staff familiarise themselves with recent events before attending ACCT reviews.

- The Director should ensure that access to craft and hobby materials is risk assessed for prisoners on an ACCT.
- The Director should share this report with PCO A, PCO B, PCO C, SPCO A and the senior manager involved.

The Investigation Process

24. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

25. The investigator visited Peterborough in April 2019. He obtained copies of relevant extracts from Ms Williamson's prison and medical records. He contacted the police officer in charge of the police investigation and exchanged information.

26. The investigator interviewed 12 members of staff at Peterborough in July 2019.

27. NHS England commissioned an independent clinical reviewer to review Ms Williamson's clinical care at the prison. The clinical reviewer joined the investigator for interviews.

28. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

29. One of our family liaison officers contacted Ms Williamson's mother to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. She asked about allegations that Ms Williamson had been bullied by staff. We have sent Ms Williamson's mother a copy of this report.

Background Information

HMP Peterborough

30. HMP Peterborough is operated by Sodexo Justice Services. It holds men and women in two separate sides of the prison. The women's side of the prison holds almost 400 women. There is 24-hour healthcare provision. All healthcare is provided by Sodexo under the provisions of their contract with the Ministry of Justice.

HM Inspectorate of Prisons

31. The most recent inspection of the women's side of HMP Peterborough took place in September 2017. Inspectors found that the segregation unit was clean and tidy and the rooms were furnished appropriately. Inspectors noted that the rates of segregation were slightly higher than they usually saw in a women's prison, although most women spent relatively short periods in the unit. Inspectors found that the female prisoners spoke highly of some of the segregation staff but they observed that a number of staff interacted too little with the women in their care. ACCT documentation was generally reasonable, and risk assessments on reception were good. Interactions between staff and prisoners in the prison generally were mostly respectful.

Independent Monitoring Board

32. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for Peterborough for the year to March 2018, the IMB noted that levels of self-harm were high. The Board considered that prisoners were treated fairly, but had some concerns about healthcare provision.

Previous deaths at HMP Peterborough

33. Ms Williamson was the third female prisoner to die at Peterborough since the beginning of 2017.

34. One of the previous deaths also took place in the segregation unit (in September 2017). Following our investigation into that death, we found that some segregation unit staff showed a lack of care and we recommended, among other things, that the Director should ensure that segregation staff:

    - have sufficient experience and training for the role;

      engage with prisoners in a meaningful way and record these interactions in the prisoners' history sheet; and

    - recognise and understand the circumstances in which they should seek managerial guidance about the prisoners in their care.

    These recommendations were accepted.

Assessment, Care in Custody and Teamwork (ACCT)

35. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

36. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

37. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation

38. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

39. The segregation unit at Peterborough is known as the Separation and Care Unit (SCU).

Psychoactive Substances (PS)

40. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

41. Ms Karen Williamson was sentenced to life imprisonment in 2011 for murder and spent time in a number of prisons. In March 2017, she was transferred to HMP Downview.

42. Ms Williamson had been diagnosed with Obsessive Compulsive Disorder and an emotionally unstable personality disorder, and her prison record showed many instances of volatile and impulsive behaviour, threatening and assaulting staff and other prisoners, making plans to escape, and damaging prison property. Such behaviour was sometimes followed by remorse and apologies to staff or prisoners who had been affected.

43. Ms Williamson had a history of self-harm and had been managed under ACCT procedures on several occasions. Her self-harm included cutting herself, tying a ligature around her neck, and taking overdoses. Her medical record showed 15 instances of self-harm prior to April 2019, three of which required hospital treatment.

44. Ms Williamson also had a history of drug misuse in the community and in prison. She had been found under the influence of drugs and had failed drug tests while in prison, most recently in July 2018. Intelligence reports in January 2019 indicated that she had been actively involved in prison drug culture.

HMP Downview

45. In 2018, as part of her sentence progression, Ms Williamson was considered for a place in a Psychologically Informed Planned Environment (PIPE) unit, a prison-led unit for prisoners with personality disorders. It was thought she would benefit from a pre-PIPE course to prepare her for this. She would need to move temporarily to HMP Send to undertake the course. She was assessed and accepted for the course but was told that there was a waiting list.

46. Ms Williamson was anxious to start the course and found the wait unsettling and her behaviour was volatile. She was rude and aggressive to staff at times and some staff recorded that she seemed to think that, because she was a life sentence prisoner, the normal rules did not apply to her.

47. On 14 February 2019, staff opened ACCT procedures for Ms Williamson. She had been in a low mood, and had 'trigger' dates pending, including the anniversary of the death of her victim and her late son's birthday. She had said that she felt that she was stagnating at Downview and had made comments about "stringing herself up". She later said that she had said this out of frustration and had no intention of harming herself but, on 18 February, she told staff that she had made a noose. She also had some issues about the effectiveness of her medication for her back pain.

48. Ms Williamson said she was looking forward to going to Send. The healthcare department addressed her medication issues. On 5 March, ACCT procedures were ended and Ms Williamson moved to Send.

HMP Send

49. Ms Williamson's records showed that her behaviour over the following days was disruptive. She did not like the regime at Send, she verbally challenged staff and was sometimes abusive and aggressive. She was based on A wing, where those prisoners undertaking the PIPE course lived, and attended D wing to undergo the 10-day induction process. When induction sessions were cancelled, staff encouraged Ms Williamson to go to D wing to associate with the other prisoners. She was not keen on doing this so would remain in her cell.

50. On 12 March, Ms Williamson told a member of staff that she had smoked 'spice' (a type of PS) since arriving at Send. Later that day, when a member of staff asked whether she had sorted out an issue with a member of the psychology team, Ms Williamson replied, "Yes, I can stop planning his murder and focus on yours." The following day she was in an office and told a member of staff that the filing cabinet should not be positioned where it was, saying, "If I were to take you hostage I could knock this over and the door would be blocked. I was thinking about it last night."

51. That afternoon, in an interview with a member of probation staff, Ms Williamson said that she was feeling depressed and threatened to take her own life if she was not transferred back to Downview. ACCT procedures were opened. In an ACCT review, Ms Williamson said she had said this out of frustration. She said she always had thoughts of self-harm but managed these. She said that she had originally felt positive about coming to Send but since arriving she felt it had been a negative experience, with lots of time locked in her cell. She was, though, looking forward to starting work in the gardens the following week and to starting the PIPE course. She said that she had no intention of harming herself or of taking her own life. It was agreed that her risk was low and ACCT procedures were closed.

52. On 14 March, Ms Williamson told a prison officer that she was unhappy with the amount of exercise she was getting, and felt that she wanted to "murder someone". She was allocated a work place on the farms and gardens, and began work there on 17 March.

53. Ms Williamson was due to begin the PIPE course on 18 March. She said, however, that she no longer wanted to engage with the PIPE process, did not want to be involved in group work, and wanted to leave Send. Staff began making arrangements for her to return to Downview.

54. At an ACCT post-closure review on 26 March, Ms Williamson said that she felt better now that she was able to use the gym and was working in the gardens. She said that she had been unsettled since arriving in Send but was now awaiting a decision on her return to Downview. She said that she had friends at Send, and was able to contact a close friend or her mother if she wanted to talk. She also said that staff had been supportive.

Events of 28 March

55. On the morning of 28 March, Ms Williamson barricaded herself in a room, armed with a pair of scissors, taking a psychologist as hostage. Prison officers soon entered the room and Ms Williamson allowed the psychologist to leave.

56. There is no segregation unit in Send. In view of the hostage incident, together with intelligence that another member of the psychology team might also be at risk, managers thought it necessary to move Ms Williamson to another prison urgently. Staff at Send contacted Downview, who said they were unable to accept Ms Williamson back at that time. Send then contacted HMP Bronzefield, but they said they could not take Ms Williamson because they had prisoners in their segregation unit who needed to be kept separate from Ms Williamson for security reasons.

57. Send then contacted Peterborough. The Head of the Offender Management Unit (OMU) at Peterborough said that they would rather not accept Ms Williamson: they had a large number of women with complex issues in their segregation unit and Ms Williamson's behaviour and self-harming had been problematic during her previous stay at Peterborough.

58. Send then contacted the Women's Team at Prison Service headquarters and asked for assistance in finding a place for Ms Williamson. The prison contacted the Deputy Director at Peterborough and explained that it was necessary to move Ms Williamson urgently, and that there were no other viable options apart from Peterborough. The Deputy Director agreed that, in the circumstances, Peterborough would accept her.

HMP Peterborough

59. Ms Williamson arrived at Peterborough at 2.28pm on the afternoon of 28 March. A cell sharing risk assessment was completed which noted a history of violence, threats to staff, multiple adjudications, hostage taking, escape risk, PS use, harassment and racist behaviour. She was deemed too high risk to share a cell.

60. A nurse conducted a reception health screen. She noted Ms Williamson's medication, and that she said that she had used PS recently. Ms Williamson denied any mental health issues. A locum GP re-prescribed Ms Williamson's medication.

61. While in reception, Ms Williamson became upset about not being allowed to retrieve a pillow from her stored property and threw a bottle of water towards a prison officer. Other officers attended and Ms Williamson, threw a punch at an officer she recognised from her previous stay in Peterborough. She was restrained and taken to the Separation and Care Unit (SCU). A prison manager authorised her to remain in the SCU for an initial period of 72 hours. A nurse noted that Ms Williamson was fit to be held in segregation.

62. CCTV footage shows that Ms Williamson arrived in the unit at 4.01pm. The unit manager, Supervising Prison Custody Officer (SPCO) A, introduced himself to her. Ms Williamson was upset and told him that she had a blade hidden in her mouth. Staff began ACCT procedures, with staff to check on her at least five times per hour. SPCO A stayed at the cell door talking to Ms Williamson but while staff were completing the documentation, Ms Williamson took the blade from her mouth and made a cut to her left arm. She was taken to the unit's holding cell for assessment. A nurse assessed the cut to Ms Williamson's arm but it was superficial and did not need dressing.

63. A mental health nurse and a prison psychologist carried out an initial segregation health screen. Ms Williamson was angry but engaged enough to report her

concerns. She said she felt low, having not been judged suitable for the PIPE course after what seemed to have been a long time working towards it. She said she had been happy at Downview and was upset at being back in Peterborough because she had been there in 2015 when she learned of her son's death from a drug overdose and this had left her with distressing associations. She said she did not want any support from the mental health team.

64. The nurse and the psychologist noted that in the current circumstances, and bearing in mind that she also had a blade concealed in her mouth, they had concerns about Ms Williamson's segregation. They recommended constant observation. They discussed this with a prison manager. He noted that in view of Ms Williamson taking a hostage that morning and then becoming violent in reception, combined with her self-harming, it was not safe for her to be held on a standard prison wing or in the healthcare centre. He authorised her continued segregation with constant observation.

65. Ms Williamson then asked to end the meeting. As they left the holding cell, SPCO A asked her to move to a different cell where staff could carry out constant observation more easily but Ms Williamson declined. He took her back to her cell and he and a prison manager continued to talk to her. Ms Williamson then agreed to move to another cell, so was taken to a cell with a photochromic door (a door made of glass which staff can make either transparent or opaque using a control panel outside the cell). SPCO A continued to talk to Ms Williamson, and eventually persuaded her to hand over the blade. She was given a radio and some books. Through the evening Ms Williamson interacted with the officer who was watching her. No issues arose overnight.

29 March

66. The following morning Ms Williamson asked for clean clothes and staff gave her some of her property. She was happy with this until she saw that some papers which contained her bank details had been searched. She became angry, shouting at staff and covering the cell door so they could not see her. SPCO A spoke to her, and she removed the covering but continued to shout, threatening to burn down her cell and to attack staff. She said that she wanted some photographs from her property, and SPCO A agreed to get them. Once she had the photographs she was calmer, and accepted her medication. She was due to attend a disciplinary hearing after the incident in reception but declined to attend and said simply that she pleaded guilty.

67. A member of the OMU spoke to Ms Williamson that afternoon. He said that the prison had contacted Downview about the possibility of her returning there but stressed that they were unable to guarantee anything. (Downview subsequently refused to accept Ms Williamson, but she was not told this before her death.) Staff escorted Ms Williamson back to reception, to complete the processes they had been unable to finish the previous day when she had become violent. While in reception, Ms Williamson apologised to the officer she had thrown the bottle of water at.

68. When she was back in the SCU, staff held an ACCT review. A senior manager chaired the meeting. It was attended by Ms Williamson, SPCO A, Prison Custody Officer (PCO) A and a mental health nurse. Ms Williamson said that she felt very

let down at being told she was unsuitable for the PIPE course at Send after having had the course set as such an important goal for her. She said she had been happy at Send and had been looking forward to making progress there. She said she had barricaded the office out of frustration. She said that she would no longer undertake any work with psychologists. She was now unsure what was next for her and was struggling to cope with thoughts of her son that had been stirred up by returning to Peterborough. She said that she had thought about harming herself every day since his death. She said she felt better than she had the previous day and she engaged with the meeting, but she said that she did not think it would take much to trigger her to harm herself again.

69. Staff judged that her risk remained raised, and that she should remain under constant observation. She raised an issue about the timing of her medication, so the healthcare department agreed to address this. Ms Williamson agreed that, although she did not wish to engage with the mental health team, she was content for them to attend ACCT reviews and to be available should she want them.

70. The nurse noted that Ms Williamson's mental health was not likely to deteriorate because she was in segregation but that the healthcare department did have concerns because she had harmed herself. The senior manager held a meeting with the nurse, SPCO A and PCO A to discuss her continued segregation.

71. They concluded that, because of the seriousness of the hostage-taking incident in Send, it would not be safe to house Ms Williamson on a standard prison wing. She had a history of self-harm and her mood had been fluctuating. Her son's birthday fell in April and this was a potential trigger for her to self-harm. In view of the potential risk she posed both to herself and to others, the SCU was considered the only location appropriate to manage these risks at that time. Ms Williamson was under constant observation and had been engaging with staff. It was agreed that staff would provide meaningful activity to prevent her from becoming bored. As an SCU prisoner she had a good level of support, and she would be relocated to a standard prison wing as soon as her risk was judged to be manageable. The meeting concluded that she would remain in the SCU, although if her level of risk changed then alternative locations would be considered.

72. At 5.00pm, Ms Williamson collected her meal but as she returned to her cell she deliberately dropped her plate. She became very agitated, demanded more food, threatened to take her own life, and demanded to see a manager. Staff obtained another hot meal for her from the kitchen. Ms Williamson apologised and accepted the food.

73. An hour later, Ms Williamson said that she had not received her hormone medication. PCO B contacted the healthcare department, and was told that the medication had been distributed in the morning. She passed the message on to Ms Williamson, who said that she had not received it, that she took hers in the evening, and would refuse it in the morning. PCO B contacted the healthcare department again. Healthcare said that Ms Williamson had signed to say she had received her hormone medication that morning. Ms Williamson said that this was untrue, and that she would refuse to take the medication in the morning as she preferred to have it in the evening. She was advised to discuss this with the doctor.

30 March

74. Staff kept Ms Williamson under observation through the night. An entry on her ACCT document on the morning of 30 March noted that she talked a lot about how she thought of killing herself every day, that she was “a monster” and that she deserved to die. Staff from the chaplaincy, the mental health team, and the Duty Director all visited the SCU. Ms Williamson complained to the Duty Director about the timing of her medication, as well as about the noise and disruption in the unit caused by other prisoners.

31 March

75. An entry in Ms Williamson’s ACCT document on 31 March shows that the senior manager chaired a meeting, which included a member of the mental health team, to assess Ms Williamson’s continued segregation. Since arriving in the unit her mood and behaviour had been ‘up and down’, with periods where she was settled, punctuated by several vocal and abusive outbursts against staff. They suspected that she was testing boundaries, as she generally engaged well with most staff and with the regime. She was given goals of continuing to comply with the regime, and not to engage in violent or aggressive behaviour or to disrupt the unit. She was entitled to in-cell hobbies, with arts and crafts materials available on request. The mental health team worker noted that Ms Williamson was settled and polite during the meeting, denying any thoughts of self-harm. She remained under constant observation. The senior manager authorised her continued segregation.

1 April

76. On 1 April, at 1.55am, Ms Williamson asked PCO B for some hot water. PCO B told her that hot water was only issued at meal times. Ms Williamson became very agitated, saying that staff were abusing her and waking her up. She shouted abuse at PCO B and other staff, making threats to assault them. An intelligence report also noted that Ms Williamson threatened to make false claims of emotional and mental abuse to get staff into trouble.

77. Entries on Ms Williamson’s ACCT ongoing record noted that she had used the telephone in her cell and then said that she had spoken to her solicitor and been advised not to talk to staff. (Records later showed that Ms Williamson had not made any phone calls at that time.) A note on her ACCT document stated that she felt suicidal and was looking for a blade but could not find one. At 4.20am, she told PCO B that she was arranging to pay to have her assaulted. A later entry noted that she told another prison officer that she realised that she had been too aggressive. At 7.20am, she refused breakfast, and was rude to staff.

78. At 7.31am, Ms Williamson telephoned a friend. She said that she had had a “dreadful” night. Prison officers had been laughing at her and antagonising her. Ms Williamson sounded irritated during the call but was reasonably calm.

79. At 8.00am, a mental health nurse saw Ms Williamson during her round of the SCU. Ms Williamson said that she had no issues. She said the same thing when chaplaincy staff did their rounds. At 9.00am, she saw a GP about some pain she

was suffering in her hand. The doctor examined her and reassured her that her condition was minor.

80. At 11.20am, the senior manager chaired an ACCT review, with Ms Williamson, a mental health nurse and one of the SCU officers. Ms Williamson said that she was still frustrated and felt that being at Peterborough was a backward step. She found the noise in the SCU distracting and wanted to move to a standard wing. She did, however, accept that staff at Peterborough were not responsible for her being there and that they were trying to arrange a transfer for her. She engaged in the review and communicated her frustration in a positive way. She said that she had no thoughts of harming herself. Those present thought that she had settled and the crisis point had passed. Her risk was marked as low, and the level of observation was reduced to a minimum of four checks per hour.

81. That afternoon, Ms Williamson asked someone from the IMB when she would be moving to a standard wing. He recorded that she was angry about being in the SCU, but when he asked if she wanted to speak to him further she became rude and declined. A PCO told Ms Williamson that managers were looking for a suitable place for her. Ms Williamson replied, “I’m not staying in the SCU, you watch.”

82. Later that afternoon, Ms Williamson asked to speak to a senior prison officer. There were none on the unit at that time so the officers asked a SPCO to come to the unit and speak to her. Ms Williamson was tearful. She said that she had been told by the senior manager that she was to move to a standard wing, and wanted to know what was happening. The SPCO told her that the senior manager was not in the prison at that time, and she had no information about a move. She advised Ms Williamson to speak to him the following day. Ms Williamson calmed down, and said that she would do so. The SPCO told the investigator that she was aware that Ms Williamson was under ACCT management, but that nothing in the brief interaction gave her any cause to think that she needed to reassess her risk level.

83. Later that afternoon, Ms Williamson shouted racist abuse at a PCO. Shortly after this she telephoned a friend. Ms Williamson was very upset and tearful, saying that she could not cope any longer and was going to end her life.

2 April

84. On 2 April, at 7.00am, PCO A was finishing her shift. As she was about to go off duty she opened Ms Williamson’s observation panel to check on her. Ms Williamson was standing on her bin, apparently trying to tie a piece of fabric to the top of the door frame. When she saw that PCO A had seen her, Ms Williamson quickly put the fabric behind her back and said, “Oh, whoops.” PCO A asked her what was the matter, and Ms Williamson asked her quite aggressively what staff were going to do about the noise being made by another prisoner in the unit. PCO A talked to her for a while, and told her that she needed to remain calm and not be so aggressive if she wanted to move from the SCU. Ms Williamson apologised. Before she went off duty, PCO A made a note on Ms Williamson’s ACCT document. She said she also told PCO C what had happened.

85. PCO A told the investigator that she thought Ms Williamson was “doing something self-harm wise”. However, she said she did not see it as a self-harm attempt but more as Ms Williamson trying to get across how much she was being disturbed and

distressed by the noise the other prisoner was making. She did not therefore see any need for her to intervene.

86. Ms Williamson declined breakfast that morning. She apologised to the PCO for being abusive the previous day. A nurse saw her on her rounds and, while Ms Williamson was not in a good mood, she did not raise any issues.

87. Peterborough holds ‘complex needs meetings’ every Tuesday afternoon. (These are multi-disciplinary meetings where prisoners with complex needs are discussed.) On the afternoon of 2 April, it was agreed at this meeting that staff would offer Ms Williamson a move to B2, a standard prison wing, as soon as a place was available.

88. That afternoon, staff held a disciplinary hearing about Ms Williamson’s abusive language to the PCO the previous day. The PCO went to collect Ms Williamson to take her to the hearing but Ms Williamson said that she did not want to attend, and was content for the matter to be addressed in her absence.

89. At 5.36pm, Ms Williamson telephoned a friend. She was fairly upbeat and said that staff were trying to arrange for her to transfer back to Downview. There were no apparent issues during the night.

3 April

90. The following morning, 3 April, Ms Williamson declined breakfast. During the medication round, she complained that she had not received all her medication. The nurse collected what had been overlooked and, when she returned to give it to Ms Williamson, Ms Williamson was rude to her.

91. When a member of the chaplaincy visited the unit, Ms Williamson was agitated. She asked if she could go to the chapel and light a candle on her son’s birthday (18 April). When told that this was a managerial decision, Ms Williamson became tense and covered her door. SPCO A asked her to remove the covering, which she did. He told her that he would be on duty that day and he would take her to the chapel. When a GP saw her on his segregation round later that morning, she was calm and raised no concerns with him.

92. At 11.15am, the senior manager chaired an ACCT review. Two nurses were present, Ms Williamson, SPCO A, and two PCOs. Ms Williamson was open and engaged with the meeting. She was angry about her medication. She wanted to receive her medication in the evening but the healthcare department said that this was not necessary, and she would continue to be given it in the morning. Ms Williamson still did not want to engage with psychologists, and said she did not feel supported. The nurse offered to review her medical records and see what support the team could offer. Ms Williamson agreed to this. She reiterated that she wanted to return to Downview. She declined the offer to relocate to B2, the standard prison wing, as she said she would prefer to return to Downview.

93. Ms Williamson denied any thoughts of wanting to harm herself, although staff noted that her son’s birthday on 18 April would be a difficult time for her. The nurse said that there was no evidence of depression or low mood. Those present felt that it was safe to reduce the level of observation to a minimum of two checks per hour.

94. That day, Ms Williamson submitted a complaint form about some of her property that had been left in Send when she was transferred. She asked for this to be restored to her or to be reimbursed.

95. At lunchtime, staff unlocked Ms Williamson so that she could collect her meal. She was wearing a dressing gown and was reminded that unit rules stated that prisoners were not allowed to collect their meals in dressing gowns. Ms Williamson refused to take the gown off, saying that she was cold. The staff offered her a jumper but Ms Williamson turned the offer down, and refused to come out of her cell to collect her meal. A PCO said that she was not angry or upset, she just refused.

96. Ms Williamson's ACCT record shows that when a PCO checked on her at 2.45pm, Ms Williamson was talking to herself. In interview, the PCO told the investigator that this was normal behaviour for her, and that Ms Williamson was calm with no apparent distress. At 2.53pm, Ms Williamson pressed her cell bell. The PCO answered, and Ms Williamson asked if her washing was available. The PCO checked, and returned with Ms Williamson's washing at 2.54pm. The PCO checked Ms Williamson again at 3.11pm, and found her standing in her cell, talking to herself.

97. At 3.42pm, a PCO went to carry out another ACCT check. As she approached the cell door, Ms Williamson called out that she was on the toilet. As a result, the PCO did not turn the opaque glass in the cell door to its transparent setting.

98. At 4.01pm, a PCO returned to the cell to check on Ms Williamson. She turned the glass in the cell door transparent and saw Ms Williamson on the cell floor. Ms Williamson had looped a ribbon over the frame of her doorway and had threaded a string (either a shoelace or the drawstring of tracksuit trousers) through the loop to form a noose round her neck. The combination had snapped but Ms Williamson had lost consciousness and was on the floor. The PCO called for assistance and other prison officers joined her as she opened the cell door. One of them called a code blue emergency on the radio, meaning a prisoner who is not breathing or is having difficulty breathing. This immediately prompted the control room to call an ambulance.

99. The PCO and a SPCO cut the string from Ms Williamson's neck and began to perform cardiopulmonary resuscitation (CPR). Medical staff had responded to the emergency call and nurses joined the prison officers in administering medical aid to Ms Williamson. They applied a defibrillator (a machine that, in certain circumstances, can apply a shock to restart the heart) but it advised them to continue CPR. They did so until ambulance paramedics arrived and took over. Paramedics transferred Ms Williamson to hospital.

100. Ms Williamson was placed in an induced coma. She remained on life support in hospital until 8 April when, following discussion between doctors and her mother, her life support machine was switched off. Ms Williamson died at 7.50pm.

Post-mortem report

101. The post-mortem found that Ms Williamson died of a lack of oxygen to the brain as a result of hanging.

102. Toxicology tests did not detect any traces of PS or other illicit drugs in Ms Williamson’s system.

103. There were traces of amitriptyline and mirtazapine (antidepressant prescription drugs which had not been prescribed to Ms Williamson). The toxicologist noted that they were present at levels that suggested they had been taken within the previous three months (that is, not immediately before her death).

Contact with Ms Williamson’s family

104. When Ms Williamson was taken to hospital on 3 April, the prison appointed a family liaison officer (FLO). She identified Ms Williamson’s mother as her next of kin and arranged for her to be brought to the hospital.

105. The FLO remained in contact with Ms Williamson’s mother while Ms Williamson was in hospital and continued to do so after she died. In line with Prison Service guidance, Peterborough offered a contribution to the costs of Ms Williamson’s funeral.

Support for prisoners and staff

106. A prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

107. When Ms Williamson was taken to hospital, staff reviewed all prisoners under ACCT management in case they had an adverse reaction to the news. When Ms Williamson died, the prison posted notices informing other prisoners of Ms Williamson’s death and offering support. Staff again reviewed all prisoners assessed as being at risk of suicide or self-harm, and all prisoners serving indeterminate sentences, in case they had been adversely affected by Ms Williamson’s death.

Findings

Ms Williamson's location

108. The decision to move Ms Williamson out of Send on 28 March was taken very quickly after Ms Williamson took a member of staff hostage at Send that morning, armed with a pair of scissors, and there was intelligence to suggest another member of staff might also be at risk. Staff in the Women's Unit at HMPPS were involved in the decision. Given the risk that Ms Williamson posed, we accept that Send did not have the facilities to hold her safely and that it was necessary to move Ms Williamson elsewhere. Downview and Bronzefield said they were unable to take her, so Peterborough reluctantly agreed that they would accept her.

109. Peterborough was not the ideal location because it had unhappy associations for Ms Williamson with the death of her son. Ms Williamson made it clear from the beginning that she did not want to be in Peterborough, and articulated this in ACCT reviews and to staff. A member of OMU staff told her that they were trying to arrange a transfer for her back to Downview (as she had been at Downview when she transferred to Send for a three-month trial) and Ms Williamson, therefore, believed that she would only be at Peterborough for a short period.

110. It emerged in our interview with the Head of OMU at Peterborough that their initial efforts to transfer Ms Williamson back to Downview had, in fact, stalled, and there were no ongoing attempts to move her at the time of her death. This message, however, had not been passed on to staff involved in the ACCT process or in the SCU, and had not therefore been passed on to Ms Williamson herself. In the ACCT review on 3 April, she and staff were still under the impression that a return to Downview was a possibility. We are satisfied, therefore, that Ms Williamson did not know that she was likely to be remaining at Peterborough when she hanged herself.

Ms Williamson's segregation

111. Segregation units are used to hold prisoners who have misbehaved or who cannot be held safely in normal prison accommodation. They inherently reduce protective factors against suicide and self-harm, such as activity and interaction with others and, for this reason, should only be used in exceptional circumstances for those known to be at risk of taking their own life.

112. We recognise that some vulnerable prisoners may also be very challenging. This can leave prison staff with some very difficult decisions about where prisoners managed under ACCT procedures should be held, in order to minimise the risk of harm to themselves as well as to others. As a result, there will sometimes be exceptional circumstances to justify holding prisoners at risk of suicide or self-harm in segregation units. However, this should only happen when all other options have been considered and exhausted.

113. Ms Williamson arrived in Peterborough as a result of a very serious incident against a member of staff. She remained unsettled and was violent towards staff in reception. Healthcare staff assessed her as suitable for segregation.

114. Once in the segregation unit, Ms Williamson said she had a blade and intended to harm herself, and cut her arm. She would not surrender the blade. ACCT procedures were appropriately opened, and healthcare staff rightly re-assessed her suitability for segregation. As they expressed concerns, the SCU manager convened a meeting. It was agreed that in view of the risks Ms Williamson presented to others, as well as to herself, she could not safely be located on a standard wing or in the healthcare unit. In order to guarantee Ms Williamson's safety, all agreed that she should be placed under constant observation in the segregation unit.

115. We are satisfied that other locations were considered and that the decision to keep Ms Williamson in the segregation unit was not unreasonable in the circumstances. We are also satisfied that the prison intended to transfer her to a standard wing as soon as possible and that Ms Williamson was told on 2 April that she would be relocated to B2 wing as soon as a place became available.

116. We are also satisfied that, in line with Prison Service policy, Ms Williamson was seen by healthcare staff, by a member of the chaplaincy, and by a senior manager every day, and that she was given a radio and in-cell hobby materials to help keep her occupied.

Risk assessment

117. ACCT procedures were correctly opened when Ms Williamson threatened to, then actually did, harm herself after her arrival at Peterborough on 28 March. We are satisfied that the decision to keep her under constant supervision (which was a resource intensive decision) indicates that staff recognised that Ms Williamson posed a high risk of suicide or self-harm at the time. Thereafter, her triggers were identified, reviews were multidisciplinary, and staff worked well to try to get Ms Williamson to engage.

118. However, we are not satisfied that Ms Williamson's risk to herself was assessed appropriately after this.

119. During the early part of 1 April, Ms Williamson was upset and agitated. At an ACCT review later that morning, her risk was marked as low and her observation level was lowered to a minimum of four checks per hour. The note of the review recorded that her crisis point had passed and she had no thoughts of harming herself. Her ACCT document, however, listed her triggers as being at Peterborough and the forthcoming anniversary of her son's birthday, both of which remained current issues for her.

120. We, recognise that staff would have been keen to get Ms Williamson off constant supervision as soon as possible (as being watched all the time may actually increase a prisoner's distress). We cannot, therefore, say that it was premature to reduce the level of supervision, especially as four checks per hour is still a high level of supervision. However, given Ms Williamson's desire to leave Peterborough, the fact that her son's birthday was approaching, her mental health issues and her volatile moods and behaviour, we consider that staff should have been aware that Ms Williamson continued to pose a risk to herself and should have been cautious about any further reduction in observations.

121. On the morning of 2 April, PCO A found Ms Williamson standing on her bin and trying to loop a piece of fabric over her door frame. PCO A made a note of the incident in the ACCT document. There were no senior prison officers on duty in the SCU at that time of the morning but she said she told PCO C what had happened before she went off duty. In interview, PCO C said that she did not recall PCO A telling her this, but accepted that it was possible she had done. PCO C did not take any further action. No-one made a note in the unit observation book. No-one informed a senior prison manager. No managerial check picked up on PCO A's note in the ongoing record.

122. The incident - an apparent attempt by a prisoner under ACCT management to make a noose – should have triggered a review of Ms Williamson's risk. We are very concerned that this did not happen and that decisions were made at the complex needs meeting that afternoon and at the ACCT review on 3 April without anyone knowing about the incident.

123. We consider that PCO A should have recognised the potential seriousness of the incident and should have ensured that it would be brought to the attention of a manager. If she told PCO C, she should have done the same.

124. In addition, we are concerned that it appears no-one read the ACCT ongoing record before the ACCT review. Unless those involved in ACCT reviews have an understanding of the prisoner's mood and behaviour in the period before the review, they are likely to assess the prisoner's level of risk on the basis of their presentation during the review. In this case, reading the ongoing record would have identified the incident on 2 April, which could then have been taken into account as indicating a possible increase in Ms Williamson's risk.

125. Even without knowledge of the incident on 2 April, however, we consider that the decision to reduce Ms Williamson's level of observations at the ACCT review on 3 April was premature.

126. Ms Williamson was known to have volatile and changing moods. The clinical reviewer noted that Ms Williamson had a diagnosis of emotionally unstable personality disorder, which is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Ms Williamson had refused breakfast that morning. She had been rude to healthcare, IMB and chaplaincy staff. She had completed a complaint form about her property. She had refused to collect her lunch after a minor issue over a dressing gown. She declined the chance to move to a standard prison wing. There remained ongoing uncertainty over her transfer out of Peterborough. She was concerned about her future after her failure in the PIPE unit. The anniversary of her son's birthday was pending.

127. Despite these many risk factors, Ms Williamson's observation levels were reduced again. We are concerned that the risk assessment on 3 April did not appear to take into account her rapidly changing presentation and the risks associated with it. We consider that the assessment was based in too large a part on Ms Williamson's presentation and her denial of any thoughts of self-harm.

128. We make the following recommendations:

The Director should ensure that staff appropriately escalate important information about prisoners under ACCT management.

The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that evidence of risk should be fully considered and balanced against how the prisoner presents.

The Director should ensure that case managers familiarise themselves with recent events before holding ACCT reviews.

The Head of Healthcare should ensure that healthcare staff familiarise themselves with recent events before attending ACCT reviews.

Access to hobby materials

129. It seems likely that the checks on Ms Williamson would not have been reduced if staff at the ACCT review on 3 April had known about the possible ligature attempt on 2 April. It also seems likely that Ms Williamson's access to possible ligature materials would have been restricted.

130. Prisoners under ACCT management, particularly in segregation, need to be able to occupy themselves. A note made on Ms Williamson's ACCT document on 31 March showed that she was allowed to have in-cell hobby materials, including craft materials. This may have been reasonable while she was under constant supervision but should have been reconsidered when the level of observations was reduced.

131. When Ms Williamson hanged herself, she used a ribbon from her craft materials to hold the ligature (noose). When police searched her cell, they found other pieces of material in her bin that she had cut to similar sizes to the ribbon. She may have been testing the strength of the different materials, and it is possible that this is what she was doing when PCO A saw her on the morning of 2 April. If PCO A had triggered an ACCT review, we would expect Ms Williamson's access to such materials to have been risk-assessed at this stage. This was an important missed opportunity.

132. We recommend:

The Director should ensure that access to craft and hobby materials is risk assessed for prisoners on an ACCT.

Allegations of bullying by staff

133. After Ms Williamson telephoned a friend on 2 April, the friend wrote to the Prison Director saying that Ms Williamson was being bullied by prison staff. The friend maintained that PCO B was a friend of the officer Ms Williamson had thrown a punch at in reception and that as a result, PCO B had been antagonising Ms Williamson.

134. Ms Williamson's mother also told the prison's FLO that after Ms Williamson died, she had received an anonymous telephone call from a man who told her that her daughter had been bullied by prison officers. (Ms Williamson's mother told the PPO's family liaison officer that she was told that Peterborough's Director had

received a similar phone call. The prison's FLO told the investigator that this was a misunderstanding. When Ms Williamson's mother said that she had received a telephone call about allegations of bullying, the FLO had told her that the Director had received a letter containing similar information. The investigator confirmed with the prison that they had not received a telephone call.)

135. After Ms Williamson died, PCO B was suspended while the prison conducted an investigation into whether she had made inappropriate comments to Ms Williamson. Several staff were interviewed, and the investigation concluded that there was no case to answer.

136. As part of our investigation we have considered whether there is evidence to support the suggestion that Ms Williamson was being bullied by some members of staff at Peterborough.

137. There are no intelligence reports suggesting that Ms Williamson complained of bullying. She did not raise this issue with healthcare staff, chaplaincy staff, or senior managers when they spoke to her daily. She did not raise it with the Independent Monitoring Board when they visited the SCU. She did not raise the issue in any of her ACCT reviews. When asked in interview whether there had been any indication or suggestion that staff had been antagonising Ms Williamson, the unit manager, SPCO A, said that he had seen nothing and had had nothing of that nature brought to his attention. The clinical reviewer noted that there are no references in Ms Williamson's medical record to any concerns about bullying.

138. The investigator viewed CCTV footage from the early hours of 1 April, when Ms Williamson became agitated and threatened PCO B. The footage does not have audio. At 1.55am, the officer on constant supervision duty stood up, and two other members of staff briefly went to the cell door, then left. Three minutes later the officer apparently spoke into his radio. At 2.07am he called another member of staff, who went to the door then left. No one was at Ms Williamson's door for a sustained period of time but we are obviously unable to establish what may or may not have been said.

139. Ms Williamson later told staff that she had made telephone calls to her solicitor and to arrange to have PCO B assaulted. However, electronic records show that she did not make any telephone calls at that time. When she telephoned her friend at 7.31am, she said that she was being bullied by staff, but did not sound particularly distressed. When she telephoned her again that afternoon she was very distressed and tearful but did not mention bullying. She was upset about her son, and her ongoing imprisonment but was not specific about what had caused her upset.

140. Ms Williamson's conversation with her friend on the morning of 1 April is the only recorded occasion on which she alleged she was being bullied. It is not clear what form she thought this bullying was taking. Although she may have genuinely believed she was being bullied, this does not necessarily mean that this is what was happening. It may be that staff were simply trying to enforce unit rules (in the same way as with other prisoners) and were not treating her unfairly or deliberately trying to intimidate or upset her. It is also worth noting that many prisoners find being on ACCT observations very stressful, especially at night when they may resent being woken up by staff using a torch to check on their well-being.

141. There is some evidence of positive attempts by staff to engage with Ms Williamson. SPCO A in particular seems to have made real efforts to calm Ms Williamson down when she became distressed. We have found no evidence that Ms Williamson was being bullied by any staff, although we cannot rule out the possibility that this was happening.

142. We are satisfied that the prison responded appropriately by conducting a prompt internal investigation.

Healthcare

143. The clinical reviewer concluded that the healthcare provided to Ms Williamson was appropriate prior to her transfer to Peterborough on 28 March.

144. However, she had concerns about the way Ms Williamson's risk was managed at Peterborough and considered that Ms Williamson's observations seem to have been reduced on the basis of her presentation during the ACCT reviews, without sufficient consideration of the context of wider risk factors still present and evidence of continued changeable behaviour associated with her personality disorder.

Substance misuse

145. Ms Williamson had a history of substance misuse, both prior to and after entering custody. She told a substance misuse worker in January 2019 that she was happy to be misusing drugs. She admitted using PS while at Send.

146. There is, however, no evidence to suggest that Ms Williamson used illicit substances after her return to Peterborough on 28 March. There are no intelligence reports about drugs. She was living under constant observation for four days from almost immediately after her arrival at the prison, and there were no signs of drug use or of any real opportunity for her to obtain any drugs. No evidence of substance misuse was found in her cell. There were no concerns about drug use in her medical records after she arrived in Peterborough.

147. Post-mortem tests did not detect any traces of PS or other illicit drugs in Ms Williamson's system. There were traces of two prescription antidepressants, neither of which had been prescribed to her. The toxicologist noted that these would have been taken within the previous three months. The clinical reviewer said this meant it was likely that she had taken these before she arrived at Peterborough.

148. We are satisfied, therefore, that Ms Williamson was not under the influence of illicit or illicitly traded drugs when she hanged herself.

Emergency response

149. When a PCO went to check on Ms Williamson at 3.42pm, Ms Williamson could see her approaching through the opaque glass door. She called out that she was at the toilet. In interview, the PCO told the investigator that she could see Ms Williamson's knees through the edge of the door which, together with the direction of her voice, made her confident that this was true. There was no reason for the PCO to have raised any concern at this stage.

150. The PCO returned to check on Ms Williamson at 4.01pm. CCTV footage shows that she raised the alarm as soon as she had turned the door to its transparent setting. Ms Williamson was on the floor on the opposite side of the cell to the toilet. This meant she had hanged herself since the PCO's previous check.

151. Colleagues ran to assist the PCO and one called a code blue emergency. This prompted the control room to call an ambulance. Staff began to attempt to resuscitate Ms Williamson immediately and were quickly joined by medical staff. Some staff said that the original code blue radio call was indistinct but the control room reiterated that it was a code blue emergency 19 seconds after the original call.

152. The PCO was not carrying a radio. This did not cause any delay in calling an emergency as colleagues carrying radios were on duty on the unit.

153. We are satisfied that the emergency response was appropriate.

154. The template that Peterborough used for the hot debrief with staff had individual sections for comments from the different departments involved in the emergency response. This allowed them to set out any points that they wanted to make, and was a helpful way of collecting information from different perspectives. We consider that this was good practice.

Sharing the report with staff

155. We consider it important that staff should be aware of our findings. We therefore recommend that:

The Director should share this report with PCO A, PCO B, PCO C, SPCO A and the senior manager involved.

Inquest

156. The inquest, held on 12 June 2023, concluded that Ms Williamson died from suicide.

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